STATE TITLE V BLOCK GRANT NARRATIVE
STATE: NV
APPLICATION YEAR: 2005

I. General Requirements
A. Letter of Transmittal
B. Face Sheet
C. Assurances and Certifications
D. Table of Contents
E. Public Input

II. Needs Assessment

III. State Overview
A. Overview
B. Agency Capacity
C. Organizational Structure
D. Other MCH Capacity
E. State Agency Coordination
F. Health Systems Capacity Indicators

IV. Priorities, Performance and Program Activities
A. Background and Overview
B. State Priorities
C. National Performance Measures
D. State Performance Measures
E. Other Program Activities
F. Technical Assistance

V. Budget Narrative
A. Expenditures
B. Budget

VI. Reporting Forms-General Information

VII. Performance and Outcome Measure Detail Sheets

VIII. Glossary

IX. Technical Notes

X. Appendices and State Supporting documents

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Nevada's Assurances and Certifications may be found on file in the office of the Chief of the Bureau of Family Health Services, Nevada's MCH Agency. The MCH Chief can be reached at jwright@nvhd.state.nv.us.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

The opportunity for oral public input on the block grant application after required public notices was provided on June 25, 2004, at two sites. One hearing was held in conjunction with a meeting of the Maternal and Child Health Advisory Board in Reno at the Washoe County District Health Department, and in Las Vegas at the Nevada Early Intervention Services conference room at the same time. No comments regarding the grant application were received at either site. Written comments were solicited due July 10, 2003. None were received. Notice of preparation of the grant, the date and places of the public hearings, and an invitation for comment was published in newspapers on July 2, 2003 in Reno, and Las Vegas. Copies of the proposed grant were available by contacting the Bureau and the NEIS in Reno, Las Vegas and Elko. Copies were sent to members of the MCHAB and those who requested them. This application represents priorities established by the Year 2000 Needs Assessment including extensive public comment through the Needs Assessment process and the meetings of the MCHAB.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

There are many factors that impact the health delivery system in Nevada. The State Health Division seeks to improve the health and well being of all Nevadans through a myriad of programs and activities. In addition its priorities include building the public health infrastructure in the state, eliminating waiting lists for Early Intervention, and addressing bioterrorism. Within this context the Maternal and Child Health (MCH) program focuses on the well being of the MCH populations of women and infants, children and adolescents, and Children with Special Health Care Needs (CSHCN), and their families, addressing in particular those priorities identified in the MCH 2000 Needs Assessment. In Nevada, the MCH Title V Program is located in the Bureau of Family Health Services (Bureau) in the State Health Division.

Nevada's Maternal and Child Health Program is dedicated to improving the health of families, with emphasis on women, infants and children, including Children with Special Health Care Needs, by promoting, assuring and providing health education, prevention activities, quality assurance and health care services.

Nevada is a semi-arid, largely mountainous state with numerous valleys of primarily north-south orientation. The Sierra Mountains form a natural barrier on the west between Nevada and California. The Great Salt Lake Desert isolates eastern Nevada from the population centers of Utah. Approximately 83% of Nevada's land area is under the jurisdiction of the Bureau of Land Management; the remaining 17 % is under private ownership or state and local jurisdiction. Nevada has thirteen Indian colonies or reservations statewide and six military bases located in five counties. As in prior years, Nevada remains the fastest growing state in the nation. In the nine months after the 2000 census was completed Clark County in the south experienced a growth of 90,000, or 6.5% growth to a total population of approximately 1,500,000. /2002/- Per the Year 2000 Census, Nevada is still the fastest growing state in the nation, with a Census established population of 1,998,257. With Nevada's growth it can be assured the State has already passed the 2 million mark in 2001. The southern region of the state received the bulk of the population in growth, leading to not only an additional congressional seat for Nevada but also redistricting for both national and state offices. /2003/ Nevada continues to be a fast growing state. In the nine months after the 2000 census was completed Clark County experienced a growth of 90,000, or 6.5% growth to a total population of approximately 1,500,000.//2003//

/2004/ The Nevada State Demographer is projecting Nevada's population will reach 2,373,543 in 2004. It is anticipated that as before most of the growth will occur in the south. //2004//

/2005/ According to Census Bureau estimates released April 8, 2004, for the 17th consecutive year Nevada remains the fastest growing state in the Nation. As predicted, most of the growth was in the south, with Clark County gaining more than 200,000 new residents. It is now number 17 on the list of largest U.S. counties, surpassing New York and Philadelphia. Rural Lyon County, in the north, ranked 15th as the fastest growing county per capita in the Nation, also according to Census Bureau figures. No end to Nevada's growth is in sight; the Nevada State Demographer projects Nevada's population will reach 2,442,116 in 2005. //2005//

Nevada's 17 counties comprise an area of 110,540 square miles, making Nevada the seventh largest state in the Nation. Of Nevada's 17 counties, Clark and Washoe are considered urban with approximately 85% of the population; Carson City, Douglas, Lyon, and Storey counties are rural; and Churchill, Esmeralda, Elko, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing and White Pine are frontier counties. It should be noted that Carson City and Elko have been designated a Small Metropolitan Area.

Nevada as a state is projected to face a fiscal downturn in the next 10 years. For this reason Governor Kenny Guinn has instructed state agencies to prepare budgets for the next biennium (2002-2003) with no increase in funding or any rate increases. Budgets are in essence in very few cases

being prepared with no increases of any kind; Maternal and Child Health (MCH) is no exception. As always, the Governor's budget will be finished sometime around September 1, 2000 (after agency submission to the governor by August 15, 2000) and will then go to the Legislative Council Bureau for development of the Legislative budget. The Legislative session that begins in February 2001 will establish the biennium budget that begins on July 1, 2001, which will be official upon signature by the Governor. In this scenario MCH expects no changes in current priorities or initiatives for 2001 as they were approved by the 1999 Legislature.

/2002/ - As anticipated, a no-growth budget was submitted and subsequently approved by the Legislature and signed by the Governor. Due to funding constraints, with the state anticipating a $120,000,000 shortfall, new programs or additional support for old programs were not possible unless alternative funding was identified. In the case of Maternal and Child Health the budget was capped. This means with the exception of Temporary Assistance for Needy Families (TANF) funds to be used to prevent out of wedlock birth in adolescents, there is no change in FY02 budget in the allocated staff and activities from the prior biennium.

/2003/ Work has begun on the budget for the 2004-2005 biennium, and again a capped no-growth budget is required. As a state that relies heavily on revenue generated from tourism, the events of September 11, 2001 have significantly affected state revenue as tourists have looked for vacations closer to home, particularly those that do not involve flying.

/2004/ The budget was capped as anticipated. While MCH did not have any additional funds appropriated it had no cuts for its programs which include CSHCN and MCH Prenatal. It was given permission to raise the fee for newborn screening to cover the cost of an active Birth Defects Registry. In addition, funding to implement the elimination of the asset test for children and pregnant women in FY05 was passed.

Early Intervention has been a priority of the State for many years, with waiting lists due to the fiscal concerns and growth in the state. In 2002 the DHR Director made the decision to move all the Early Intervention (E.I.) programs into one Bureau in the State Health Division. Formerly they were in two Divisions (Health and Child and Family Services) with program oversight (lead agency) in the Director's office. The FY04-FY05 budget contained this transfer, was approved by the Governor, and approved by the Legislature. The budget also contained a $5 million dollar increase to address the waiting lists.

On July 1, 2003, a new Bureau of Early Intervention Services was created, combining the E.I. services formerly in the State Health Division's Bureau of Family Health Services (supervised by Title V), the services in the Division of Child and Family Services, and in the Director's Office. In addition, as noted above, the Governor recommended and the Legislature approved a $5 million dollar increase to address the waiting lists. These dollars represent the Governor's commitment to the care and education of the state's young children. While MCH will no longer be supervising E.I. services, it will work closely with the new Bureau to ensure collaboration with the CSHCN and other programs of the Bureau.

In addition to moving all E.I. services to a new Bureau in the State Health Division, the State Head Start Collaboration was moved to the Welfare Division with the Child Care Program. MCH works very closely with these two programs to ensure the health needs of children in Head Start and Child Care are addressed. The MCH Chief sits on the Committees for both programs. //2004//

/2005/ The fees for newborn screening were raised and will cover the reinstitution of an active Birth Defects Registry in Nevada, effective July 1, 2004. Preparation for the FY06-FY07 budget has begun. Again a no-growth budget is required, with general fund limited to two times the FY05 allocation plus any salary adjustments. //2005//

These priorities and initiatives are based on the MCH Five-Year Needs Assessment completed in February 1996 and July 2000 and subsequently updated. They include:

An overarching approach to Nevada's priority needs identified below, continues to be to identify ethnic, gender and age demographics of targeted populations, and use culturally appropriate assumptions and strategies to design and implement initiatives.

1. The teen pregnancy rates, particularly those of minorities, should be reduced.
2. The use of tobacco, alcohol, marijuana and other drugs among adolescents should be reduced.
3. The rate of child abuse and neglect should be reduced.
4. The incidence of Fetal Alcohol Syndrome should be reduced.
5. All women should have access to prenatal and postpartum services, which include medical and dental care, regardless of ability to pay.
6. The incidence of low and very low birthweight babies should be reduced.
7. Children with Special Health Care Needs in the state should have access to specialty and subspecialty services, including care coordination.
8. Children with Special Health Care Needs in the state should have access to quality day care, baby sitting and pre-school services.
9. The incidence of Early Childhood Caries in Nevada's children should be reduced.
10. Every child in Nevada ages zero to twenty-one should have a home for primary care, including dental care.

The Needs Assessment submitted with this application will guide the planning in coming years as far as funding allows. As will be seen, the findings of this current Needs Assessment , with the exception of those around mental health, will not lead to significant changes in the priorities or initiatives of Nevada's MCH Program, including Children with Special Health Care Needs (CSHCN). Included in the Needs Assessment beginning is a discussion of the effects of poverty, non-citizenship, racial and ethnic disparities in health status, geography, urbanization and private sector impacts on the delivery of services for the MCH population. /2002/ no change.//2002//

/2003/ no change. /2004/ no change// ***/2005/ no change //2005//***

/2004/ In addition to the fiscal situation there are many factors that impact the health services delivery system in the state. The extreme rurality of most of Nevada is one that leads to many challenges in developing a health services delivery system in the state. This is compounded by a lack of providers for both primary and specialty care that is even seen in the most urban communities. MCH supervises the Primary Care Development Center (PCDC), Nevada's PCO. The PCDC is responsible for conducting the surveys necessary to establish Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). HPSAs can be primary care, dental or mental health shortages and have a very high patient to provider ratio. These designations help with the recruitment of providers to underserved areas.

PCDC also manages the J-1 Visa program, which places foreign physicians in underserved areas. In FY03 the process for selecting J-1 Visa physicians was changed to give priority to those who serve in a Federally Qualified Health Center or Tribal Health Center, and to not approve any physicians who would be working at a non-primary care site. Currently, of Nevada's 17 counties, 10 in their entirety are Primary Care and Dental HPSAs, and 12 in their entirety are Mental HPSAs. With the exception of Carson City, the rest of the counties are partial HPSAs in all three designations.

/2005/ These designations help with the recruitment of providers to underserved communities through several programs that PCDC administers. In addition to the J-1 Visa Waiver program, PCDC administers the SEARCH training program for health care students, the Quentin Burdick Interdisciplinary Training program, and the National Health Service Corps. The J-1 Visa program, known as the Conrad 30 program, places foreign medical graduate physicians in medially underserved areas where it is often very difficult to recruit physicians. In FY 04 there are approximately 55 J-1 physicians practicing throughout Nevada, over 80 health care students have received training through the SEARCH program, and 17 health care professionals have been placed through the National Health Service Corps . //2005//

The PCDC works closely with the PCA, the Great Basin Primary Care Association (GBPCA), to promote the placement of health services personnel in underserved areas. It is working with GBPCA in implementing its Statewide Strategic Plan to develop at least 10 new primary care sites over the next five years. It is also working with GBPCA in several community development initiatives around primary care, the largest being in Las Vegas. PCDC also develops sites and places National Health Service Corp (NHSC) and SEARCH providers in clinical and pre-clinical rotations. //2004//

/2005/ PCDC also works with Nevada Health Centers, Office of Rural Health, University of Nevada School of Medicine, Nevada Rural Hospital Partners, Area Health Education Centers, Washoe County Access to Healthcare Network, and Clark County Health Access Consortium. //2005//.

Nevada Check Up:
Nevada Check Up is Nevada's Child Health Insurance Program. It is a program of the Division of Health Care Financing and Policy (DHCFP) in DHR. Nevada Check Up and the Bureau work closely together to ensure services needed by Nevada's children are provided.

By May 1, 2000, Nevada Check Up, Nevada's Child Health Insurance Program, reached a milestone of 10,000 children enrolled in the program and receiving health services. By June 1, 2000, Nevada Check Up had 11,164 children enrolled and receiving health services. The program is entering a new phase of administration and organization, in which a targeted outcome-based marketing and outreach program will play a prominent role in achieving maximum enrollment and participation in the children's health insurance program.

Among immediate changes to the program were a rapid elimination of an application backlog, reassessment of staff function and allocation of staffing resources, a reinstitution of a state programs and community partners Marketing and Outreach Advisory Team, investigation of instituting a "premium lock box" contract with the state's bank to collect the quarterly premium payment, and the submission of a State Plan Amendment to the Health Care Financing Administration (HCFA) to: (1) waive cost sharing (i.e., Nevada Check Up quarterly premiums) for American Indians and Alaska Natives; (2) change the re-determination process from annual to rolling, providing ongoing eligibility for 12 months after the date of a child's most recent enrollment; and (3) remove the six month residency requirements prior to a child's eligibility.

To complement the planning and implementation of a renewed marketing and outreach plan, Nevada intends to submit a State Plan Amendment to HCFA to: (1) increase the administrative cap from 10% to 15% based on health care expenditures; (2) base the 10% administrative cap on federal monies allocated to the state per federal fiscal year; or, (3) remove marketing/outreach from the administrative cap and base it on 1% of the available federal monies allocated to the state per federal fiscal year. /2002/ As of June 2001, enrollment in Nevada Check up was approaching 20,000. This represents a 75% increase over the enrollment level in June 2000.

In order to support the program's growth, additional staffing was authorized and recruited during 2001. Nevada Check up is now fully staffed. The program continues to build on previous marketing initiatives, with a greater emphasis on matching results to specific activities. This will enable staff to further refine outreach efforts to targeted populations. Nevada Check Up has adopted a passive redetermination process that will make it more user-friendly and easier for children to stay enrolled. A new on-line application was implemented May 1, 2001, which will expedite the application process. A process is being established to link the Welfare database with the Nevada Check Up database to streamline and promote eligibility between Medicaid and Nevada Check Up. Starting in September 2000, Nevada Check Up children began receiving dental services through contracted HMOs.

/2003/ Nevada Check Up eligibility continues to grow. In the spring of 2002 the Chief of Medicaid Managed Care/Nevada Check Up reported an enrollment of 23,389. He also reported the program is

receiving 900-1,000 new applications a month, with an enrollment of 24,000 anticipated by the end of April 2002. In spite of the state's tight budget climate, enrollment for Nevada Check Up has not been capped. Supplemental funds, however, will have to be appropriated in FY 03 to allow growth to continue in FY03.

/2004/ Along with other states, Nevada grappled with budgetary challenges during its just ended Legislative Session. In fact, the inability to reach agreement on a balanced budget has resulted in a Special Legislative Session in order to resolve the taxing plan necessary to meet revenue needs over the next two fiscal years. Despite the fiscal challenges, the Legislature generally accepted the budgets proposed for Medicaid and
Nevada Check Up. There was discussion but no decision to impose an enrollment cap on Nevada Check Up program enrollment. In large part, the acceptance reflects recognition by the Legislators that the budget submitted by the Division of Health Care Financing and Policy already incorporated cost containment measures. Key initiatives include adherence to a targeted rate of return for the contracted managed care plans that serve the Medicaid TANF/CHAP and Nevada Check Up programs. In order to offset rising medical costs, the maximum level of premiums charges by Nevada Check Up to its enrolled members was raised from $50 per quarter to $70 per quarter. Nevada Check Up enrollment stands at 23,700. Approximately 80% of Nevada Check Up enrollees are served by the contracted managed care plans including the dental benefits in the south. //2004//

/2005/ As of May 2004, Nevada Check Up enrollment totaled 26, 439. This represents an increase of 11.6% over the prior year. Enrollment growth benefited from continuing outreach activities under the Covering Kids grant as well as operational changes to simplify enrollments. Approximately 81% of Nevada Check Up members are enrolled in a managed care plan. //2005//

Managed Care in Nevada:
Managed Care in Nevada continues to have low market penetration, with 20.1% overall as of December 1999. Of this 18.2% is Commercial, 33.6% Medicare and 84% Medicaid enrollment. As managed care for the Medicaid population was fully implemented in 1999, the 84% penetration represents a 148% increase since December 1998 when it was fully implemented. Dental services continue to not be included in Nevada's Health Maintenance Organization (HMO) benefit packages, but rather remain fee-for-service. As of December 1999 there were 9 licensed HMOs in Nevada as predicted. There were 98 provider organizations (PPOs), a small increase from the 93 of a year ago. /2002/ Nevada Managed Care average market penetration was 31.7% for 2000, an increase of 11.6% from 1999. Of the total market penetration, 16.6% was commercial, 36.9% was Medicare, and 42.8% Medicaid. Commercial enrollment had less than a 2% decrease from prior year, however, Medicaid HMO enrollment dropped by 41.3% from 1999. Medicare HMO enrollment saw a slight increase of 3.3 from the previous year. Ten HMOs were licensed in Nevada to provide health care in 2000; however, one HMO was acquired, leaving nine HMO's by the end of the year. There were 110 provider organizations (PPOs), a 17% since 1998.

Medicaid managed care current enrollment totals 41,300 participants in Clark and Washoe Counties. This represents an annual increase of 91.5%. Ninety-five percent of the total enrollment is in Clark County. Of the three contracted HMO's in Clark County in FY01, one ceased participation in the Medicaid program June 30, 2001, leaving 2 remaining.

/2005/ Effective February 1, 2004, enrollment in a managed care plan for Medicaid TANF/CHAP recipients residing in urban Washoe County became mandatory. The shift from voluntary to mandatory managed care enrollment reflected the entry of a second HMO into the service area. As of May 2004, a total of 12,623 recipients are enrolled in managed care. Approximately 10,800 of these recipients were previously served under fee-for-service. //2005//

/2003/ As of March, 2002, there are only 7 licensed HMOs in Nevada. HMO Commercial enrollment was at 18.9%, Medicare enrollment at 38.7%, and Medicaid at 38.9 %. Medicaid managed care is mandated only in Clark County, as there are not two HMO's available to Medicaid clients in the rest of

the state. Medicaid clients in Washoe County and the rural counties can choose to remain fee-for-service.

Dental managed care for Medicaid and Nevada Check Up clients (primarily children) went into effect in Clark County January 1, 2002 through a contract between Medicaid and the University of Nevada Las Vegas (UNLV) School of Dentistry. Both managed care plans in Clark County have contracted with UNVL for this service. The School is networking with dentists in the community who were previously Medicaid providers to expand the provider base. Families call a central phone number that is located at the Dental School and can choose the location where they want to receive services. Families already in treatment have been allowed to continue with their original provider for six months if that provider is not now in the managed care system. There is no prior authorization for children's dental services unless there are specialty services needed. Medicaid has worked very closely with the Bureau through this implementation, ensuring CSHCN with Cleft/Craniofacial conditions in particular do not have to change dental/orthodontic providers mid-treatment. In the spring of 2002 callers to the central phone number were averaging 1,000 a week, with a 45-day wait for an appointment. The goal is a 30-day wait.

/2004/ The request within the Medicaid program budget to eliminate the CHAP assets test for CHAP applicants was approved. This proposal had been submitted but eliminated from the Medicaid budget during prior Legislative Sessions. The elimination is effective beginning in FY 2005.

In the spring of 2003 both Clark and Washoe County were covered by Medicaid and Nevada Check Up managed care. In Clark it is mandatory for both; in Washoe it is voluntary for Nevada Check UP. The total number of TANF/CHAP eligible participants in managed care in the two areas was 86,997, a 9.47% growth from the same time the prior year, and includes 98.29% of those in Clark County. A planned expansion of Managed Care in Washoe County in FY 04 will lead to mandatory Managed Care in that county also. Key initiatives include adherence to a targeted rate of return for the contracted managed care plans that serve the Medicaid TANF/CHAP and Nevada Check Up programs.

At this time there are seven HMOs licensed in the state. //2004//

/2005/ For 2004 there remain seven HMOs licensed in the state. Of these, two serve the Medicaid and Nevada Check Up populations in Clark and Washoe Counties. As there are now two HMOs in Washoe County that serve Medicaid and Nevada Check Up, managed care is mandated for both populations. The market penetration of HMOs effective September, 2003, was 16.8% commercial, 37.9% Medicare, 44.9% Medicaid, and less than 1% Nevada Check Up. //2005//

/2005/ Transportation for Medicaid and Nevada Check Up:

In order to reduce lack of transportation as a barrier to accessing care, an initiative establishing a contracted, statewide Medicaid/Nevada Check Up transportation broker was completed. The non-emergency transportation broker, Logisticare, provides the Medicaid and Nevada Check Up populations with a toll-free 1-800 number at which transportation may be arranged to and from an appointment for covered services. The companion benefit from the centralized transportation broker is ability to work with the provider community in coordinating appointment schedules for members who live in more remote areas, particularly for high frequency services such as dialysis. This is a positive factor for Medicaid providers and is a fiscal benefit to the state. Since Logisticare began operations in October 2004, it is averaging over 20,000 trips per month. //2005//

Temporary Assistance for Needy Families (TANF):
Nevada saw the loss of TANF assistance for many families in January 2000 when they reached the 24-month limitation established by Nevada policy. An audit report of the Welfare Division dated February 23, 2000, notes the Welfare Division does not have information readily available to

determine the extent in which employment and training programs help welfare clients become self-sufficient, and thus did not have an adequate mechanism to track what happens to clients who leave TANF. The Welfare Division developed a plan to survey and track former clients of its New Employees of Nevada (NEON) training and employment program. A study by the University of Nevada consisting of a monthly survey requested by the Welfare Division began in the spring of this year for those individuals who have left TANF during the previous month. This survey of randomly selected clients is performed at 3, 6, 12, 18, and 24-month intervals after they leave TANF assistance. As this study has just started a report is not yet available.

In spite of the dropping off of families due to the 24 month limitation, Nevada saw its Welfare rolls rise more than 6% during April 2000 to 16,421 recipients from a low of 15,487 in March 2000. This rise was mirrored in Food Stamps and Medicaid. It is not clear at this time whether the rise is a trend; it is being watched closely by Welfare Division and MCH officials. The officials note however that the number of TANF recipients is no where near the record high point in caseload in March 1995, when Nevada had 42,703 people on what was then Welfare. Nevada's long-term decline in Welfare/TANF rolls is attributed in part to the state's strong economy with record low rates of unemployment and welfare reform efforts that include child care dollars that exceed TANF dollars for families in transition and job retention initiatives for those going off TANF.

/2002/ The Welfare Division reports the pilot study conducted last year to determine the impact of loss of benefits on families was not a success. Welfare has developed an improved project plan that began in February 2001. Telephone surveys are conducted on households starting with the first month they were off assistance, and then subsequently at 3, 6, 12, 18, and 24 month intervals. University of Nevada -- Reno will begin mailing a survey forms to these households. Preliminary results of the telephone surveys are anticipated in early summer 2001.

From March 1995 to March 2001, Nevada experienced a 55.6 % decrease in TANF cash grant recipients. However, since March 2000, TANF caseload increased approximately 22 percent from 15,487 to 18,962 recipients. When evaluating this increase three contributing factors stand out:
* Changing economy;
* Recipients returning to the program after a 12 month sit-out; and
* An increased payment to relatives caring for children in their home.

The increased payment to relatives caring for children in their home has had the greatest impact on caseload. These cases increased from 17 percent of the TANF caseload in January 1997 to an estimated 29.5% as of April 2001.

During the next biennium Welfare anticipates this trend to continue. The three factors mentioned will continue to play a roll, as well as three other changes being implemented over FY02:
* Family Preservation Program - Effective July 1, 2001 families with a profoundly or severely mentally retarded child/ren or children under the age of 6 years with developmental delays, that have an income that does not exceed 500 percent of the federal poverty level, can receive a $350 monthly payment. This program is to help these families maintain these children in the home and prevent placement in an institution. This will begin with a pilot project for up to 120 children. It was reported at the Maternal and Child Health Advisory Board meeting on June 30, 2001, that 119 children were already enrolled in the program.
* Kinship Care Program - Effective October 1, 2001. This program is designed to promote a safe and permanent home for children who are residing with certain relatives who have obtained legal guardianship of the child because of the absence or inability of the child's parent to care for them. Families meeting the requirements of this program will receive a higher TANF grant than other TANF families.
* Families with Ill/Incapacitated Members - Effective January 1, 2002. Family with a primary wage earner who is ill or incapacitated, or is required to care for a family member who is ill or incapacitated, will receive a higher TANF cash payment. This change will be spread over two years.

The Bureau will be closely watching the implementation of these new TANF changes, particularly the

Family Preservation Program. It has the potential of significantly impacting Nevada's Early Intervention programs in that families who are eligible for TANF are also eligible for Medicaid. Increasing eligibility to 500% could significantly increase the number of families that could qualify leading to increased Medicaid revenue for the Early Intervention programs and fewer children eligible for the Bureau's CSHCN program due to prior resources.

/2003/ Nevada has seen the number of people receiving Welfare almost double the March 2000 low number . Much of the increase has been attributed to the September 11(9-1-1) attacks. The Governor has made a commitment that any one whose employment has been affected by 9-1-1 will have any unemployment benefits disregarded for TANF. All the initiatives described under /2002/ scheduled to be initiated over the past year were, including Kinship Care, higher TANF cash payments for families with an ill/incapacitated member, and family preservation.

Through a partnership between the SHD and the Welfare Division, $500,000 in TANF funding has been allocated to the SHD for teen pregnancy prevention activities. The 2001 legislature passed SB 367authorizing this funding, and also establishing a State Partnership to Prevent Teen Pregnancy (SPPTP). The Bureau formerly sponsored an Interagency Group for Teen Pregnancy Prevention that collaborated around teen pregnancy prevention activities. This has now been replaced by the SPPTP. Several members of the old Interagency Team are now on the SPPTP. Others serve as staff to it. Members of the SPPTP were defined by SB 367, which expires by limitation on July 1, 2005. The Administrator of the Health Division or a person designated by the Administrator serves as Chair. Other members include one representative of the Department of Education, one person who is employed as a teacher or a school counselor, one social worker licensed pursuant to NRS, one representative of an agency of juvenile justice in the state, one representative of a family court in the state, one provider of health care authorized to practice in the state, one representative of a faith-based organization, one parent who resides in the state who is not employed by the state or a local government, one representative of a child-placing agency licensed pursuant to NRS, two persons who represent different populations with high rates of teen pregnancy as determined by the Administrator, and not more than two additional persons who possess qualifications suitable to carry out the duties of the SPPTP.

/2004/ TANF in Nevada is seeing its caseload finally level after 9/11. After reaching an all-time high in May 2002 of 35,122 recipients, the April 2003 caseload of 28,909 was the lowest since November 2001. Food Stamp recipients, however, reached an all-time high of 108,264 recipients. The TANF dollars available for teen pregnancy prevention activities are not available in the coming biennium.

The Welfare Division did complete a survey on TANF Leavers, reported in September 2002, with the last data received in June 2002. It reported that over one half of former TANF recipients in the sample were employed at the time of the survey (51.9%). Average hourly wage was $8.35 with the average hours of work per week equal to 34.2 hours. Thirty-five percent of those not working at the time of the survey had been recently employed. Of those working, 37.7% had health benefits, and another 22% reported they would have health benefits at some point. The average number of years spent on TANF was 2.35 years. Fifteen percent had spent more than five years receiving cash assistance. By six months out, 15.9% had gone back on TANF. The survey is available on Welfare's web-site at http://welfare.state.nv.us. The survey and follow-up studies are providing information needed by Welfare and its partners, including MCH, to target initiatives designed to keep individuals off TANF, such as child care. //2004//

/2005/ The number of TANF Cash Grant recipients has declined in 8 of the last 12 months. As of April 2004, the cash assistance caseload had declined 5,579 average recipients per month, or 19%, from one year ago. Even with this decline, the April 2004 caseload (23,330 recipients) was still almost 2,900 recipients higher than July 2001. This is an indicator that despite the continuing improvement and stabilization of Nevada's economy, the division is still experiencing residual effects from the economic recession of 2001 which was exacerbated by the tragic events of September 11, 2001.

Welfare's Food Stamp caseload continues to grow. In March 2004, Nevada's Food Stamp program reached a new historical peak of 122,138 participants. In addition to lingering effects of the decline in Nevada's economy, Nevada's growing population has led to increased Food Stamp participation. Also, Food Stamps are now distributed through electronic swipe cards similar to debit cards. The elimination of actual coupons has helped relieve the social stigma some people held, and enrollment has grown. (The growth in Food Stamps mirrors the growth in WIC, with both seeing similar increases. WIC is close to 48,000 participants a month with a potential to go to 60,000 in the next year and a half.)

Nevada's Medicaid Eligible caseload also continues to grow, increasing an average of 9,815 recipients per month, or 5.9%, from one year ago. The strongest growth in Medicaid has occurred within the group of individuals who receive medical assistance only (no cash). This group is referred to as TANF-Related Medical Only. In April 2004, Nevada's Medicaid Eligibles reached a new historical peak of 176,396 recipients (including a projected factor for retroactive eligibility); approximately 65% of these are children. Currently, 74 out of every 1,000 Nevadans are receiving some sort of Medicaid service. //2005//

/2005/ In August 2003, the income limit for the Family Preservation Program changed from 500% to 300% of the federal poverty level.

The following changes are Effective July 1, 2004:

Automatic Medicaid enrollment of newborns is effective the day of the mother's expected delivery date. When TANF eligibility elements are verified at the time the agency is notified of the child's birth, cash for the newborn is added to the TANF household.

The Welfare Division is implementing a significant policy change to the Child Health Assurance Plan (CHAP) program within Medicaid, which covers pregnant women and children. The asset test will be removed. Assets/resources of household members will no longer be considered in determining eligibility for CHAP benefits. However, previously countable resources will be tracked, so the division may report on how many individuals who would have been determined ineligible prior to July 1, 2004 are determined eligible under the new policy provisions. The Maternal and Child Health Advisory Board is extremely interested in this change and its effect on coverage and thus access to care, and have requested an update on it at every Board meeting.

The Kinship Care Program payment allowance will increase to the levels originally granted when the program began in October 2001. The Kinship Care Program provides a TANF payment allowance, which is 90% of the foster care rate. Children age 13 or older receive a higher payment than children 12 and under. Each eligible child receives a payment equal to the payment for one child.

Due to budget shortfalls, the Welfare Division did not implement a higher TANF cash payment for families with Ill/Incapacitated Member. //2005//

B. AGENCY CAPACITY

The Bureau works to leverage its resources to promote and protect the health of the MCH populations it serves including CSHCN. It does this through partnering and collaborating with a myriad of agencies and programs, both government and private, across the state. Many of those efforts are described in this Section.

Program authority for Nevada's MCH and CSHCN programs are contained in Nevada Revised Statutes (NRS) and Nevada Administrative Codes (NAC) as follows:
* NRS 442.120-170, inclusive. Designates the department of human resources through the health division to "Cooperate with the duly constituted federal authorities in the administration of those parts

of the Social Security Act which relate to maternal and child health services and the care and treatment of children with special health care needs".
* NRS 442.130. Designates DHR as the agency of the state to administer, through the SHD, a MCH program, and to advise the administration of those services included in the program that are not directly administered by it. "The purpose of such a program shall be to develop, extend and improve health services, and to provide for the development of demonstration services in needy areas for mothers and children".
* NRS 442.133. Establishes the Maternal and Child Health Advisory Board. The purpose of the Board is to advise the Administrator of the SHD concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of children.
* NRS 442.140. Authorizes a state plan for MCH.
* NRS 442.180-230. Authorizes the department (DHR) to "administer a program of service for children who have special health care needs or who suffering from conditions which lead to a handicap, and to supervise the administration of those services included in the program which are not administered directly by it."
* NRS 442.190. Authorizes a state plan for children with special health care needs.
* NRS 442.115. Authorizes the State Board of Health (also appointed by the Governor) to adopt regulations governing "examinations for the discovery of preventable inheritable disorders, including tests for the presence of sickle cell anemia". The follow-up for those whose examinations and tests "reveal the existence of such a condition" is described in this statute also. The newborn screening program is placed in the Bureau.
* NRS 442.320-330. Authorizes the establishment of a Birth Defects Registry
* NAC 442. Maternal and Child Health. Establishes regulations for the CSHCN and MCH prenatal programs regarding eligibility, covered conditions and so forth. It establishes the protocol for the taking of blood samples from infants for newborn screening, establishes fees for services of the Bureau of Early Intervention Services' Early Intervention Services, and the nurses of the Bureau of Community Health Services, and defines level of care of hospital neonatal units. It also establishes the provisions for the operation of the Bureau's Birth Defect Registry. ***/2005/ In the coming year the portion establishing the MCH Prenatal Program eligibility will be deleted through the state's regulatory process (see below). //2005//***

All of the above statutes and regulations impact the operations of Nevada's MCH and CSHCN programs by giving state authority for the programs to the SHD and setting operating regulations into state law. This ensures the programs operate within legal boundaries established and monitored by the state. /2004/ In addition to the authority for MCH, CSHCN, Newborn Screening and the Birth Defects registry contained in NRS and NAC, the state budget process also places MCHB's Abstinence Education, SSDI, and Newborn Hearing grants, WIC, PCDC, the Center for Disease Control and Prevention's (CDC's) Oral Health, Rape Prevention and Injury Prevention grants and the Centers for Medicare and Medicaid Real Choice Systems Change grant within Bureau operations. //2004// ***/2005/ In FY04 the MCHB funded Early Childhood Comprehensive Systems grant was added. //2005//***

The Bureau seeks to work closely with state's public health community including the Clark County Health District (CCHD) and Washoe County District Health Department (WCDHD) to promote the health and well being of the MCH/CSHCN populations in those counties, as well as with the other Bureaus of the SHD. Title V funding provides support for WCDHD, CCHD and Community Health Nursing Services of the Bureau of Community Health Services. In Washoe County funding supports the MCH program of home visiting for women and infants and an adolescent health clinic. In Clark County funding supports an adolescent health clinic including an oral health initiative. Title V funding provides some support for Community Health Nursing in Nevada's rural and frontier counties.

The Bureau is home of small programs that are payors of last resort for the treatment of CSHCN and prenatal care for pregnant women. These programs act as safety-net providers for eligible individuals who do not meet the eligibility requirements for Medicaid, Supplemental Security Income (SSI which includes Medicaid in Nevada), or Nevada Check Up, and otherwise meet the eligibility requirements contained in NAC. For covered children the program will pay for specialty and subspecialty care, and

primary care and dental care if the child does not have insurance. CSHCN staff refer potential eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made. The CSHCN data system has been revised and converted to new software that allows automated data matches with Newborn Screening, the Birth Defects Registry, Medicaid claims, Vital Statistics and Newborn Hearing Screening program. This enables staff to better track what programs and/or initiatives are following the children, services received, etc. The monitoring of eligibility of children referred to Medicaid and Nevada Check Up is now accomplished on-line. For those pregnant women who are eligible for MCH Prenatal the program will pay for dental care and other services deemed necessary to produce a healthy birth outcome. The MCH Prenatal program does not cover labor and delivery. For those children who are SSI eligible the program supports services that are not covered by Medicaid such as specialty foods required by some children with metabolic disorders. Eligibility for both programs is currently established at 250% of the Federal Poverty Level, with legal residency in the Nation and Nevada residency required.

/2005/ The MCH Prenatal Program was discontinued May 15, 2004. The Bureau will continue to provide obstetrical services for low-income, high-risk women through a new program called the Maternal and Child Health Campaign. The Bureau will have contracts with community providers. These community, direct-service providers will screen all clients for social service and nutritional needs, referring to various community agencies as needed, in addition to providing obstetrical services. Entry into prenatal care is particularly low among Hispanic women. All contracted agencies with the Bureau are to offer bilingual (English and Spanish) service, and have culturally appropriate materials. //2005//

The Bureau is linked electronically with Medicaid and Nevada Check Up eligibility records in order to check eligibility and prevent duplications. This is possible through NRS, which allows sharing of information between Divisions of the Department of Human Resources and ensures confidentiality of those communications.

The Bureau has an Information and Referral Line (IRL) that serves as a referral source for families in need of pediatric care, with referrals to Nevada Check Up, Medicaid, and pediatric providers a service offered through the IRL. The IRL has been a primary component for signing up women, infant and children for Medicaid and Nevada Check Up as well as referring them and their families to other services such as WIC, immunizations, etc. All who call are queried regarding their insurance status. If they do not have or have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA and the Bureau's MCH Prenatal and CSHCN programs.

The Bureau has a web-page where a description of Bureau programs and initiatives may be found and links to web-pages either specific to the Bureau such as Oral Health and WIC or relative to MCH such as the Interactive Data Base of the Center for Health Data and Research that is partially supported by the SSDI grant. The Bureau web-page is located at http://health2k.state.nv.us/bfhs/. The Prenatal web-page contains information on how to have a healthy pregnancy, infant care, well child issues, teen pregnancy issues, and many other topics related to maternal and child health. It is one of the most popular web-pages on the SHD web-page, receiving several hundred hits a week.

The Bureau continually works to partner with Medicaid in promoting the health and well-being of Medicaid pregnant women and then their infants. The Bureau Chief was a member of the review panel for Medicaid HMO contracts earlier this year and the Medicaid Managed Care Chief sat on the review panel for the Bureau's newborn screening laboratory contract. Through contacts between the two agencies and interaction before the Maternal and Child Health Advisory Board (MCHAB) MCH is able to bring concerns about both Medicaid and Nevada Check Up to the attention of the regulatory agency and see them addressed as much as possible. The Bureau continues to look for ways to perform outreach for Nevada Check Up and Medicaid. Referrals to Nevada Check Up and Medicaid are made through the CSHCN and MCH Prenatal Programs, the Prenatal campaign and WIC.

The Bureau continues to work closely with the University of Nevada School of Medicine (UNSOM).

Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, Diabetes, Endocrinology, and Cleft/Craniofacial clinics in Reno and Las Vegas. ***/2005/ In FY04 the Endocrinology clinic was dropped as there are now pediatric Endocrinology specialists available in Reno and Las Vegas. //2005//***

/2004/ As in years pass the Bureau has not been very successful in partnering with the Vocational Rehabilitation, Rehabilitation, Community Based Services, and Developmental Disabilities Planning Council of the Department of Employment, Rehabilitation and Training (DETR). This may change. The 2003 Legislature moved Community Based Services from DETR to DHR and also created in DHR a new Office of Disability Services and moved to it from DETR the state's Traumatic Brain Injury program. The Bureau anticipates working very closely with the new Office of Disability Services and Community Based Services when they are in DHR. This move was effective July 1, 2003, but it will take a few months to work it out. Historically the programs in DETR have not worked with children; the new Office of Disability Services will. //2004// ***/2005/ The Office of Disability Services is working closely with the Real Choice Systems Change project discussed below, particularly on the area of transition of CSHCN to adulthood. //2005//***

The Health Division is the recipient of a three-year Centers for Medicare and Medicaid Services (CMS) $1,385,000 grant to build systems of care for Children with Special Health Care Needs. This is a "Real Choice Systems Change" grant. /2004/Due to a delay in implementing the grant only a media campaign has occurred as yet but more will in the coming year. Included in the proposal, however, was a complete needs assessment of CSHCN in Nevada to provide a better understanding of the nature and magnitude of challenges facing CSHCN ages birth to 22 and their families in Nevada (e.g., the level of need, amount of services available, amount of services required, service gaps, service duplications, etc.). The data generated by this study will help address CSHCN systems development. The project also calls for the development of pilot projects in the second and third years to address the findings of the needs assessment such as gaps in community-based systems.//2004//

/2005/ The Real Choice Systems Change grant became fully staffed in February, 2004. A statewide needs assessment vendor was selected in April, 2004 and the assessment of current services, gaps and needs, and duplication of services will be completed by January 2005. The data generated from the in-depth needs assessment will be used to develop public policy initiatives and demonstration projects to ensure coordinated, family-focused, and community-integrated systems of care for all of Nevada's Children with Special Health Care Needs. This includes family partnership in system planning and service selection, effective supports for CSHCN transitioning to adult life, and better-coordinated care throughout childhood and into young adulthood. //2005//

The Bureau continues its efforts to work with agencies to promote access to prenatal care including those whose services target high risk Hispanic and African American Women. The Economic Opportunity Board (EOB) serves areas of Las Vegas and North Las Vegas with high minority populations. The MCH contract with EOB provides support for appropriate obstetric services for their clients. It has WIC clinics on site. Through PCDC MCH works with Nevada Health Centers as they develop clinics, particularly those in Las Vegas replacing Community Health Centers of Southern Nevada, to include the provision of prenatal care in their services. Nevada Health Centers have clinics in the primarily African American and Hispanic areas of Las Vegas and North Las Vegas.

Through the Prenatal campaign, Nevada's MCH supports and promotes a network of prenatal providers who served pregnant women regardless of ability to pay. The campaign has a bilingual multi-media campaign designed to promote early and continuous entry into prenatal care and promote healthy preconceptual and prenatal behaviors. Callers to the IRL receive information regarding sources for coverage of prenatal care as well as to any other referrals requested by the caller. The multi-media campaign and staffing of the IRL is provided in English and Spanish. /2004/ While the current Prenatal campaign is called Baby Your Baby (BYB), the future of BYB is up in the air. The Bureau will continue a prenatal program to take its place to continue the IRL and outreach campaign.

Effort to recruit providers, particularly rural providers will continue. //2004//

Baby Your Baby also has a pediatric component for children to age five, including infants. BYB pediatric providers are in Clark and Washoe Counties, and in the rural communities of Armagosa, Austin, Beatty, Elko, Eureka, Gerlack, Hawthorne, Pahrump and Carson City. This will continue should BYB end in the state. The multi-media component of the pediatric campaign encourages families to seek a Medical Home for their children and provide public health education on the value of primary and preventive care. The multi-media campaign is using Bright Futures to guide the content of the multi-media campaign. Callers to the IRL for pediatric information are referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the pediatric campaign have also agreed to see children, including infants, regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients.

/2005/ As anticipated, the Baby Your Baby campaign involvement by the Bureau was discontinued December 31, 2003. In its place is the Maternal and Child Health Campaign. This campaign has a three-pronged approach to accomplishing its goals. Low-income, high-risk pregnant women will receive care through community providers who have contracts with the Bureau to provide these services. The second element of the campaign is to provide a toll-free, statewide information and referral line for all Nevadans needing information or assistance regarding pregnancy or child health matters. The third element of the campaign is to conduct a mass-media campaign, in both English and Spanish that educates the public about pregnancy and other related matters.

Although the Baby Your Baby campaign has ended, the Bureau continues to have a list of pediatric providers in all counties that are willing to see children for a discounted or sliding scale fee. Callers to the Maternal and Child Health Line are referred to these pediatric providers. In addition, the mass-media campaign will be emphasizing the need for children to find a "medical home" and the importance of good nutrition during pregnancy to help prevent low-birth weight babies. //2005//

The Bureau's Oral Health Unit is working with Medicaid to promote dental coverage for pregnant women, as dental disease has been linked to low birth weight. It also works with Great Basin Primary Care Association (GBPCA) and its members to develop sites and providers for dental services in underserved areas. It is partnering with St. Mary's Foundation in Reno and others as well as local school districts to provide a statewide sealant program.

The Primary Care Development Center partners very closely with the Great Basin Primary Care Association and its members to promote access to primary care for all Nevadans including pregnant women, infants, children and adolescents, and CSHCN. In many rural parts of the state as well as in Washoe and Clark Counties GBPCA members are the only providers available for primary care including infant well-child and other care. In addition, the Community Health Nurses of the BCH provide well-child services for infants.

MCH will continue to support Adolescent Clinics in Reno and Las Vegas. These are provided under contract with Washoe County District Health Department and Clark County Health District. The Child and Adolescent Health Coordinator will work with the Adolescent Clinics in the coming year to assure they continue to address identified needs.

The MCH Chief serves on DHR's Child Care Advisory Committee, representing the SHD to promote health concerns. The Child Care Steering Committee includes representatives of Health, Welfare, Dept. of Education, Nevada's Community Colleges, University of Nevada, Head Start, Welfare contractors, Consumers, Family to Family Connection, etc. It is charged with advising the Department of Human Resources and the Governor on improving quality and availability of child care for Nevada's children, particularly those services provided to TANF recipients and clients who are receiving transition services from TANF. The MCH Chief is one of 4 state employees on this Committee.

The Bureau has teamed with the University of Nevada Reno (UNR) Cooperative Extension Services, the Children's Cabinet in Northern Nevada and the Economic Opportunity Board of Southern Nevada to obtain training for a team of four people at the University of North Carolina Chapel Hill on Child Care Health Consulting. This was a four-month program whose goal was to "train the trainer". The goal as a Child Care Health Consultant trainer is to educate the Child Care Health Consultants to adopt a comprehensive picture of the child care environment so that s/he will see that each component of healthy development - health, safety, social behavior, and intellectual skills, - is equally important, and no one component stands in isolation. Instead, all elements are interdependent, acting in concert to provide children with healthy, safe, and developmentally appropriate social, emotional, intellectual, and physical stimulation. Another goal is to create a link between health care providers and the child care community. An MCH funded member of the Bureau staff is one of the trainers for this project and for now is the only one who is active.

/2005/ One person in Southern Nevada was trained to be a Child Care Health Consultant. The Child Care Health Consultant program is in transition due to lack of funding and loss of their lead Child Care Health Consultant trainer. The MCH funded member continues to be available to child care providers for consultation and to train staff in the prevention of illnesses within a child care setting. //2005//

The MCH Chief participates in the Title V-B Steering committee for Family Preservation and Support. The MCH Chief will continue work to ensure MCH concerns are addressed in any changes to Nevada's Title IV-B program. Through the DHR Child Care Advisory Committee, the MCH Chief continues to promote the inclusion of training for care of CSHCN in all training initiatives. The inclusion of CSHCN in all publicly funded child care including those sites receiving assistance with development and training from Welfare is also promoted.

The Bureau works with all known parent and advocacy groups such as "Nevada Partners in Policymaking" and the "Nevada Dual Sensory Impairment Project", to discuss available programs and accessing services within the community. Activities have included meetings and panel discussions with consumers in both Reno and Las Vegas to discuss the scope of services covered by Title V programs, as well as developing linkages with other agencies such as Medicaid, Nevada Check-Up, Vocational Rehabilitation, Shriner's, and the Department of Education, for access to, and coordination of services. The meetings included a cross section of consumers, many of whom are adults with disabilities, as well as the parents and foster parents, of children who have a variety of disabilities and needs. This also provided an opportunity to dialogue with members of the community and the staff of multiple community agencies. As a result, there is increased communication within a growing network of service organizations and consumers. Nevada Partners in Policy Making were very prominent in assuring parents of CSHCN input into the MCH Needs Assessment, and have assisted with implementing its findings. The CSHCN program now includes information about Family Voices in all its communications with families. All of these agencies and consumers were involved in the development of the Real Systems Change grant application, and have been involved in its implementation, providing the public information campaign that was accomplished this year and funded by the grant.

C. ORGANIZATIONAL STRUCTURE

/2004/ Nevada's Executive Government is set up with the elected Governor as the Head of State. The current Governor is Kenny Guinn, now in his second four-year term. Under the Governor are the various Departments that along with Boards and Commissions that make up the Executive Branch, including Human Resources, Employment, Rehabilitation and Training, Information Technology, Motor Vehicles, Public Safety, Conservation and Natural Resources, Cultural Affairs, Administration, Personnel, Agriculture, and Business and Industry. The Legislative Branch includes the Senate and Assembly, the Legislative Counsel Bureau and Legislative Committees. The Judicial Branch includes

the court system, commissions and the State Board of Pardons. An org chart of Nevada State Government may be found at http://www.leg.state.nv.us/lcb/research/2002StateOrgChart.pdg. //2004//

/2005/ no change //2005//

The Department of Human Resources (DHR) includes the state public health agency, the State Health Division (SHD). Other agencies in DHR include the state mental health agency, the Division of Mental Health/Developmental Services; the social services/child welfare agency the Division of Child and Family Services; Aging; the Medicaid and Nevada Check Up agency, the Division of Health Care Financing and Policy; and the TANF and Child Care Block Grant agency, Welfare. Mike Willden is the Director of DHR. The org chart for may be found at http://hr.state.nv.us/Documents/dhr-org.pdf. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives.

As noted in III.B, Agency Capacity, Nevada Revised Statute 442 designates the Department of Human Resources through the State Health Division to administer those parts of the Social Security Act which relate to Maternal and Child Health and the care and treatment of Children with Special Health Care Needs. Within the SHD the MCH and CSHCN programs are in the Bureau of Family Health Services.

The SHD contains 7 Bureaus all headed by a Bureau Chief. In addition to the Bureau of Family Health Services they include Community Health (BCH), Licensure and Certification (BLC), Health Planning and Vital Statistics (BHP&VS), /2004/ Early Intervention Services (BEIS) as of July 1, 2003//2004//, Health Protection Services (BHS), and Alcohol and Drug Abuse (BADA). Yvonne Sylva is the Administrator of the SHD. /2004/ The State Health Officer position is currently vacant but is slated to be filled in August by Dr. Bradford Lee.//2004// ***/2005/ The SDH organization chart is available electronically at III.B, Agency Capacity.//2005//***

/2005/ The State Health Officer's position was filled by Bradford Lee, M.D, J.D.. Dr. Lee came to the SHD from the United States Air Force, where he served for more than 29 years. His medical degree is from Howard University, College of Medicine; his Juris Doctorate is from the University of the Pacific McGeorge School of Law.

Yvonne Sylva, MPA, who has been the Administrator of the SHD since 1992, retired in June 2004. Alex Haartz, MPH, formerly Deputy Administrator, was appointed Administrator on July 6, 2004. Mr. Haartz received his MPH from Tulane University. Prior to coming to the SHD he was with the San Diego County Department of Health providing public health education. He began his career with the SHD with the Bureau, and is an advocate for MCH. //2005//

The Bureau works very closely with all six of the other Bureaus. It provides funding for Community Health Nurses in BCH and partners with BCH on many chronic disease initiatives. The Center for Health Data and Research in the BHP&VS works with the SSDI grant and produces the data for the MCH Block Grant application. BADA works with the Bureau on its Perinatal Substance Abuse Prevention initiative, particularly focusing on adolescents. While the Bureau's Oral Health Unit has the fluoride initiative, BHP has the engineers that monitor the water systems. The Bureau works with BLC on emergency medical services and on Newborn Intensive Care Unit regulations. /2004/ Finally, the new BEIS is collocated with the Bureau and will work closely with the CSHCN program and other Bureau initiatives. Title V funds support the BEIS services. The Bureau org chart is attached. //2004//

The Bureau of Family Health Services under the SHD Administration is responsible for Title V MCH Block Grant oversight, management and reporting. The Bureau has many programs and initiatives that all go to promote the health and well being of Nevada's families. /2004/Judith Wright is the Bureau Chief. //2004//

The MCH Prenatal and CSHCN Programs have already been described in III.B. Agency Capacity. They pay for treatment for eligible pregnant women and children. The CSHCN program includes Newborn Screening, Newborn Hearing Screening, and the Birth Defects Registry. These three

programs are all required by NRS. The Newborn Screening and Birth Defects Registry programs are funded by newborn screening fee revenue Newborn Hearing is funded by HRSA. CSHCN also includes the Real Choice Systems Change Grant that is funded by CMS.

/2005/ The portion of the MCH Prenatal program that pays for treatment for eligible pregnant women has been changed to contracting with community agencies to provide pregnant women with direct services at the community level.

As noted in III. B, the Baby Your Baby campaign has been replaced with community-based direct services by contracted obstetrical providers. Its replacement is discussed in the Annual Plan. //2005//

The MCH Prenatal Program includes the Perinatal Substance Abuse Prevention program, the Prenatal Campaign (currently Baby Your Baby), and Domestic Violence, Injury and Rape prevention programs. Injury and Rape Prevention are funded by CDC.

/2004/ The MCH Prenatal and CSHCN Programs are headed by Health Program Specialist IIs. //2004//

The Child and Adolescent Health Program addresses teen pregnancy prevention and other initiatives to promote the health and well-being of Nevada's children and adolescents. It includes the Abstinence Only grant funded by HRSA. /2004/ It is headed by a Health Program Specialist II. //2004// ***/2005/ It also includes the MCHB Early Childhood Systems Development grant, and with the additional funding from the MCH BLock Grant the state received is adding a component for Early Childhood for ages 6-10. //2005//***

The Oral Health Unit includes a statewide sealant initiative, a fluoride initiative, and is developing an oral health curriculum for primary and secondary education. It is funded by CDC. /2004/ The Oral Health Unit is headed by a Health Resource Analyst III. //2004/. ***//2005/ The Oral Health Unit is headed by a Health Program Specialist II rather than a HRA III as previously proposed. //2005//***

The WIC Program has clinics statewide. It is currently serving approximately 43,000 participants a month. It is USDA funded. /2004/ It is headed by a Health Program Manager II. /2004// ***/2005/ WIC currently serves approximately 46,000 participants per month and expects to reach 48,000 in the near future. //2005//***

The Primary Care Development Center works to promote access to primary care statewide. It has the Primary Care grant from the Bureau of Primary Health Care, the NHSC SEARCH and Quentin N. Burdick Program from the Bureau of Health Professions, and the HRSA funded SSDI program. /2004/ It is headed by a Health Resource Analyst III. //2004//

/2004/ Nevada's MCH Program is advised by a Maternal and Child Health Advisory Board (MCHAB). It was first established through an executive order in 1989, and then was established in statute in 1991 by NRS 442.133. It is comprised of 9 individuals appointed by the Governor to two year terms, and two legislators appointed by the Legislative Counsel. Its composition represents public health, providers, legislators and a consumer who always represents CSHCN. Per NRS the MCHAB is advisory to the Administrator of the SHD. They are charged to advise the Administrator concerning "perinatal care to enhance the survivability and health of infants and mothers, and concerning initiatives to improve the health of pre-school children". They meet 4 to 6 times a year, alternating between Reno and Las Vegas. They respond quickly to issues as they come up and have testified before the Legislature on bills of concern to the Department. They produce a bi-annual report includes a report of their activities for the biennium and recommendations for the coming biennium. This report is placed on the Bureau's web-page and some hard copies distributed at the Legislature. The MCHAB is staffed by the MCH Bureau Chief.

The State Board of Health (SBOH) is a regulatory body that is staffed by the SHD Administrator. As

MCH is not regulatory it does not have much activity before the SBOH, but it does go before them to set fees for Newborn Screening. The Bureau is also currently partnering with BLC to update the NICU regulations, which must be approved by the SBOH before they become state law. //2004// ***/2005/ The Newborn Screening fee increase was approved in September 2003; the NICU regulations were approved in June, 2004. //2005//***

Specific staff of the Bureau are listed in III D. Other (MCH) Capacity.

Title V funding is also placed as previously mentioned in the Community Health Nursing budget and in Early Intervention Services. Both programs work with the Bureau and provide the reporting required by the block grant. The MCH Bureau Chief assures the funding is being spent in accordance with federal regulation.

D. OTHER MCH CAPACITY

Nevada's MCH/CSHCN programs, located in the Bureau, are managed through its main office in Carson City, Nevada. Staff who are located in the Carson City office are listed in the attached table.

Two contractors, both Health Educators, one a Registered Dental Hygienist, currently staff the Bureau's Oral Health Unit. They are funded by Title V. One contractor is working on the Teen Pregnancy Prevention initiative, funded by the Abstinence-only grant. A request to turn the Abstinence-only contract into a Full Time Employee (FTE) (classified) is currently in process.

The Bureau Carson City office also contains the state Special Supplemental Food Program for Women, Infants and Children (WIC) staff, a total of 9 FTEs including the Health Program Manager II WIC, 2 Registered Dietitians, a Management Analyst II, and clerical, technical and accounting support staff. Additional state staff including 3 Registered Dietitians and program support staff are located in WIC clinics in Nevada's 15 rural and frontier counties. (WIC services in Clark and Washoe counties are provided through contracts with the SHD).

/2002/ - A Teen Pregnancy Prevention contractor who is half-time has been hired. For oral health there is now one contractor, Title V supported, and one half-time contractor supported by a Centers for Disease Control and Prevention Fluoride grant. Both are Registered Dental Hygienists. Due to the Legislative Session conversion of contractors to FTEs has been put on hold, but will be pursued in the next biennium. The Title V oral health, Teen Pregnancy Prevention, and Abstinence contractors will be converted. It addition, the WIC Program has recently hired a 1 FTE breastfeeding coordinator, approved in 2001 by the Interim Finance Committee.

In July of 2001, the SHD was notified that it is the recipient of a CDC grant that will enable the establishment of a State Oral Health office in Nevada. Notice of Grant Award was received on July 5, 2001. This five-year grant will fund a State Dental Officer, a Health Resource Analyst II, a Health Educator and a clerical position. With the conversion of the Title V oral health contractor, the SHD will have 5 FTEs dedicated to oral health.

In addition, a Bureau contractor is working on the Birth Defects Registry in Las Vegas. A request to turn the contract into an FTE has been approved and hiring is in process. Both the SCCs have special needs parents on staff to provide assistance and support to the families served by the clinics. /2002/ - Karen Power, MPH, has been hired for the Birth Defects Registry (BDR). Recruitment is currently in process for a half-time contractor to work on the BDR in the north.

/2003/ The abstinence contract has been converted to an FTE, but the Title V oral health contractor has not. Oral Health continues to be staffed by one and one-half contractor/ consultants, and 4 FTE. The Health Resource Analyst II (HRA II) position is in the process of being reclassified to a beginning level biostatistician as HRA II turned out not to be the appropriate classification for oral health

surveillance. The Oral Health program Specialist II is currently staffed by a contractor/consultant, Chris Forsch RDH. The FTE will be filled when the classification requirements can be met, which include a bachelor's degree in a related field. WIC has added an FTE breastfeeding coordinator. Finally, an administrative assistant has been hired for the Oral Health Program.

Out-stationed personnel in the Bureau, supported by Title V, are reflected in the following table:
Employee Number of FTEs Job Titles/Responsibilities/Location
Karon Felten, Peggy Nipp /2003/ vacant 1 CSHCN Registered Dietitians (job sharing) /2003/ no longer a job share position

/2003/ Due to the lack of funding for the BDR this FTE has been eliminated. Plans for the half-time contractor in the north have been temporarily put on hold. Staff are investigating resources to complete BDR abstracting in the north and all rural areas so that the state will have one full year (2001) of data for the entire state. Karen Power moved on to become the manager of the Health Division's Cancer Registry.
Biographies of managers may be found attached. There are a total of 130.25 FTEs and contractors in the Bureau.

/2004/ The 2003 Legislature approved increasing newborn screening fee to support the Birth Defects Registry. As this application is written the regulatory process to increase the fee is in process. When it is in place the FTE will be reinstated. The half-time contractor was hired to complete the data collection in the north, giving the state one full year of statewide birth defects data. FTEs in the Special Children's Clinics have been deleted from the Bureau listing as they have been moved to the new Bureau of Early Intervention Services. The FTE for the Oral Health Coordinator is being reclassified to a Health Resource Analyst III. This leaves a total of 60 FTEs and 5 contractors in the Bureau. There are no special needs parents on staff. //2004//

/2004/ Judith Wright, Bureau Chief, is a graduate of the University of Chicago, Chicago, IL. She has been in Public Health since 1978, and MCH specifically since 1989, having formerly served as CSHCN Director in Montana. She came to Nevada to become Bureau Chief in September 1994

Gloria Deyhle, RN, CSHCN Manager, got her nursing degree from Mount Sinai Hospital School of Nursing. She has been CSHCN Manager since 1990, having previously worked as a Medicaid Services Specialist in the Welfare Division.

Cynthia Huth, CNM, Women's Health/Perinatal Coordinator, received her MS in Nursing/Midwifery from the University of Utah. She was a practicing midwife until 1996 when she came to work for the Bureau as a Perinatal Nurse Consultant.

Mark Hemmings, PCDC Manager, received his Masters from Central Michigan University (Extension), Honolulu, Hawaii. Before becoming manager of the PCDC in 2002 he was a Health Resource Analyst in the Bureau of Health Planning and Statistics.

Doug Schrauth, WIC Manager, is a graduate of Cal-State University in Hayward, CA. Before coming to be WIC Manager in 2002 he was SHD Internal Auditor.

Steve Kepp, Administrative Services Officer, received his MBA from Nova Southeastern University in Florida. Before coming to the SHD in 1998 he worked for a Construction company in Wyoming. /2004/

/2005/ Staff for several new grants received by the Bureau were approved and filled as were several vacancies.

The following key personnel have joined as Bureau staff:

Kyle Devine, received his MSW from University of Nevada Reno, and is the Bureau's new Child

and Adolescent Coordinator. Prior to coming to the State he worked for Lassen Diversified Management of Susanville California in charge of their Tobacco Control initiative.

Christine Forsch, Health Program Specialist II (not a Health Resource Analyst III as reported last year), Oral Health Program Manager, is a graduate of Kennedy Western University, and a Registered Dental Hygienist (RDH). Prior to becoming the Oral health Program Manager, she served as the State's Oral Health lead as a contractor in the Bureau. In addition the Oral Health Program has a biostatistician, a Health Educator, two half-time RDH contractor educators, and an Administrative Assistant.

Dana Zive, Health Program Manager I, Real Choice Systems Change, received her MPH from San Jose State University. She had formerly worked for the Bureau in the Baby Your Baby Program and most recently worked for ETR Associates in Scotts Valley, California. Unfortunately, she will be moving and resigned effective June 18, 2004. Recruitment to replace her is in process. The RCSC initiative also has a Management Analyst II and an Administrative Assistant.

The WIC program released a Request for Application for WIC agencies who would take over state run clinics. This RFA was successful and state run WIC agencies in 5 rural counties were converted to contracted agencies as are those in Clark and Washoe Counties. A second RFA is currently in process to add more contracted agencies in Clark and Washoe Counties and in rural counties where there is interest in taking over from the state. The goal is to have the state WIC office get out of providing direct services and assume a solely management role. Additionally, WIC is on task to convert WIC benefits to Electronic Benefit Transfer (EBT), and has added a contractor to work on the conversion. It has also added a contractor to help with vendor monitoring and a contractor to help with financial management of the program, for a total of 3 WIC contractors.

The State Board of Health did approve the newborn screening fee increase. Documents to reestablish the Birth Defects Registry Health Program Specialist I were submitted to State Personnel and have been approved. Hiring is in process and the Bureau expects to hire early in FY05.

The state has funded a Health Program Specialist I FTE with the Early Childhood Systems Development (ECSD) grant to undertake those grant activities. This FTE started April 26, 2004. The ECSD grant is also funding 1/4th of an FTE Administrative Assistant.

The Newborn Hearing Screening (NBHS)grant has also funded a Health Program Specialist I FTE, which was filled in the fall. Unfortunately this employee was let go in April 2004. Due to the decreasing funding in this grant the Bureau now plans to hire a contractor to work on the NBHS project until the grant ends in FY06.

In FFY04 the State received an additional $414,494 in Title V MCH Block Grant funding. Activities to be supported by this increased funding include a Health Program Specialist I to head up initiatives for young children six to ten, and partially fund an Administrative Assistant for the Child and Adolescent Health program (the rest of the funding for the Administrative Assistant will come from the ECSD and Abstinence grants). Other uses of the additional funds are addressed in the Annual Plan.

These changes currently leave Nevada's MCH Program with 52.5 FTEs and 4 contractors, or temporary employees as they are now called. See the attached chart for the breakdown. //2005//

E. STATE AGENCY COORDINATION

As indicated in III.C, the agencies of public health (State Health Division), mental health (Division of Mental Health/Developmental Services), social services/child welfare (Division of Child and Family Services), Medicaid and Nevada Check Up (Division of Health Care Financing and Policy), Aging and Welfare are located within the Department of Human Resources. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives. /2002/ no change. /2003/ no change /2004/ no change. //2004// ***/2005/ //no change //2005//***

The Bureau works closely with all the Bureaus of the SHD in one manner or another as discussed in III.B and IV.B and IV.C. This includes the Bureaus of Alcohol and Drug Abuse (BADA), Health Planning and Vital Statistics (HP&VS), Health Protection Services (HPS), Community Health (BCH), and Licensure and Certification (BLC). /2003/ no change //2003//. /2004/ The Bureau of Early Intervention Services (BEIS)is added as all the Early Intervention Services in the state are rolled into one Bureau in the SHD. The main office of this Bureau is co-located with the Bureau in Carson City. //2004// ***/2005/ no change //2005//***

The Bureau partners with the Department of Education and with local (county) school districts around the state on many initiatives around child and adolescent health. These include the Youth Risk Behavior Survey (which includes the Safe and Drug Free School Survey), Teen Pregnancy Prevention, and Perinatal Substance Abuse including Fetal Alcohol Syndrome Prevention. It is currently working with the Department of Education on an oral health curriculum for schools. The Bureau also works with Juvenile Probation of the Department of Corrections on teen pregnancy prevention, substance abuse, and injury issues.

As in years pass the Bureau has not been very successful in partnering with the Vocational Rehabilitation, Rehabilitation, Community Based Services, and Developmental Disabilities Planning Council of the Department of Employment, Rehabilitation and Training (DETR) in spite of a recent partnering on youth workforce initiatives. This relationship may change for the better as the newly appointed (as of June 19, 2000) Director of DETR was formerly the Administrator for Welfare and before that Administrator of SHD. The coming year will see what changes this appointment will bring. /2002/ no change to date.//2002//

/2003/ A Strategic Planning Disability Task Force: Committee: Children's Disabilities Subcommittees:

The 2001 Nevada Legislature passed AB513, which appropriated funds for the development of four long-term strategic plans relating to the health care needs of Nevada residents. The project is lead by a Steering Committee to which four Task Forces report, one of which is for Disabilities. The other Task Forces are looking at Seniors, Rural Health and Rates.

The Disability plan is to "ensure the availability and accessibility of a continuum of services that appropriately meet the basic needs of persons with disabilities in Nevada". The MCH Chief is serving on a Children's Subcommittee to the Disabilities Task Force for AB 513. The funds supported the hiring of a contractor to work with the Disabilities Task Force and develop the Strategic Plan. As this grant is written the Children's Subcommittee is still meeting and the first draft of the plan has not been produced. Its recommendations will go to the full Disabilities Task Force and then to the Steering Committee for AB513.

The Task Force through the contractor is charged with researching and documenting current resources and services systems statewide. It is to complete a statewide analysis of demographics and services and supports, involving focus groups and subcommittees. It is also to complete an analysis/evaluation of best practice service and supports, compare them to the current resources and services systems statewide, and produce a Strategic Plan draft. The draft plan is to include cost analyses, funding proposals, implementation strategies. It is then to be presented to the public and a final camera-ready report prepared based on public input. A record of the solicitation of input from the public is to be included in the final plan. The final plan is to be completed in September 2002. The

Strategic Plan, once accepted, will be the basis for legislative consideration during the 2003 Legislative Session.

The Children's Subcommittee has worked primarily to ensure a children's focus in the deliberations of the contractor, which have primarily gotten through identifying best practices. For example, many of the initial documents produced by the contractor have started the analysis at age 15, or age 5, missing the infant and toddler and young children issues. The Subcommittee has worked to ensure children from birth to transition to adulthood are addressed. The Strategic Plan is to address mental disabilities and related conditions, physical/neurological disabilities, and sensory disabilities for Nevadans of all ages, by income and by place of residence. The Children's Subcommittee, which has a wide representation of children's advocates, has worked to ensure the contractor has information on all the known resources and gaps in the state, and possible solutions proposed by the group.

The Children's Subcommittee has provided the contractor with input on consumer target areas, what they see as children's issues, key beliefs and values, and their perception of major trends. The outcome, as expressed in the Values/Key Beliefs Statements, is that every Nevadan with a disability lives, works and learns in an integrated community and feels at home there. They and their families have real choices, the services and supports they require for independent and inclusive living, and equal opportunity for quality of life. Services must be available throughout Nevada for every disabling condition, systems of care should be consumer-centered, family-focused and community based, and over all culturally competent. Services should be comprehensive, individualized and least restrictive. The documents produced so far are extensive, but the overall tone is that Nevada's system for disabilities should enable all to reach full potential regardless of their disability or condition. The final products of AB 513 should impact CSHCN and will be a consideration as the Real Choice Systems Change grant is implemented. //2003//

/2004/ Based on this study the 2003 Legislature moved Community Based Services from DETR to DHR and also created in DHR a new Office of Disability Services and moved to it from DETR the state's Traumatic Brain Injury program. The Bureau anticipates working very closely with the new Office of Disability Services and Community Based Services when they are in DHR. This move was effective July 1, 2003, but it will take a few months to work it out. The same bill also establishes an Advisory Committee on Deaf and Hard of Hearing Persons in the Office. It is anticipated that the Bureau's Newborn Hearing initiative will work with this Committee. Historically the programs in DETR have not worked with children; the new Office of Disability Services will. //2004//

/2005/ The Office of Disability Services is working closely with the Real Choice Systems Change project discussed in III B. //2005//

/2005/ In addition to the Office of Disability Services, the Real Choice Systems Change grant has allowed the development of improved coordination and communication with several other state agencies. The project staff is currently working on the development of a scope of work for an interagency agreement with Medicaid's Continuum of Care Office, which coordinates many CSHCN services for eligible children including school-based services, Katie Beckett, and EPSDT. DHCFP representatives have been very positive about creating a stronger relationship between CSHCN programs and their offices.

The RCSC project team is also in the process of developing an interagency working group to bring all providers of services for the CSHCN population together. This group will include representation from BFHS CSHCN Program, Medicaid's Continuum of Care Office, Welfare, Nevada Check Up, DETR (Specifically Vocational Rehabilitation), the Bureau of Early Intervention Services, the Department of Education, and the Office of Disability Services. While coordination with some agencies is easier than with others, there has been interest in developing a cross-departmental system of care for CSHCN and the RCSC project is working to take advantage of this culture of change.

The RCSC project housed in the BFHS is also working closely with another Real Choice grant,

awarded in FY2003 to the Office of Disability Services and managed by the Northern Nevada Council for Independent Living. A scope of work for an interlocal agreement is being developed and should be in place by June, 2004. This Real Choice grant is aimed at assisting non-elderly Medicaid recipients and is looking at both diversion and transition by changing the policies of the Medicaid program and to increase the capacity of community services.

The Real Choice Project Team has also been attending meetings of and working with the Transition Forum, a subcommittee of the Governor's Council on Rehabilitation and Employment of People With Disabilities. This forum addresses issues inherent to transitioning youth with special health care needs and has formal relationships with DETR and school districts.

The Nevada Advisory Council for Children with Special Health Care Needs will be created through the RCSC grant by September, 2004. This 13-member council's membership includes parents of CSHCN, adolescent CSHCN, advocates, providers, and educators. The Advisory Council will serve to guide project activities and to provide a forum for issues of interest to Nevada's CSHCN and their families. The Real Choice program manager will act as a liaison between the Advisory Council and the Children's Disability Subcommittee created as part of the Disability Task Force to assure that project activities are in line with the objectives of Nevada's Strategic Plan for People with Disabilities. //2005//

The Bureau continues to work closely with the University of Nevada School of Medicine (UNSOM). The Birth Defects Registry initiative when it gets up and running again will partner with the UNSOM Department of Pediatrics' Geneticists to provide consultation in its development and implementation. Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, Endocrinology, and Cleft/Craniofacial clinics in Reno and Las Vegas. /2004/ The Bureau also works closely with AHEC, whether it is using their expertise to plan and conduct meetings or the partnership with PCDC on rural mental health issues. //2004//

The Bureau partners closely with the Clark County Health District (CCHD) and Washoe County District Health Department (WCDHD), which both have MCH programs. They are the only two county health departments in Nevada. The remaining 15 counties are served through the SHD. Representatives of the CCHD and WCDHD sit on the Maternal and Child Health Advisory Board and work very closely with the Bureau on MCH issues. /2002/ no change. /2003/ no change //2003// /2004/ no change// ***/2005/ no change. //2005//***

Through the PDCD the Bureau works very closely with the Great Basin Primary Care Association (the state's PCA) and its members to promote access to primary, dental and mental care for underserved Nevadans. These members include Federally Qualified Health Centers, Tribal Clinics, Rural Health Centers, Nevada Health Centers, etc.

The WIC Program is in the Bureau and partners with many of the other programs in the Bureau such as Oral Health and Women's Health/Perinatal.

The Teen Pregnancy Prevention initiative works with the various Family Planning organizations in the State, including those services of the Community Health Nurses of BCH and the private organizations in Reno and Las Vegas. ***/2005/ In 2004 Nevada was one of several states selected to work together on developing a common Action Plan around Teen Pregnancy, STD, and HIV/AIDS prevention. This initiative is continuing and will continue into FY05. //2005//***

Through the partnership the Bureau has with Medicaid and Nevada Check Up, Bureau programs are referral sources for both programs. A separate agreement covers the Prenatal campaign program which is a partnership between Medicaid (in DHCFP) and the SHD, as well as private sponsors. It is a referral source for both pregnant women and for children to age 5 to Medicaid and Nevada Check Up. Conversely, they are referral sources for MCH Prenatal, CSHCN and WIC. Through the Prenatal

program many of the hospitals have developed intake workers on site for Medicaid. The Bureau has a contract with the Economic Opportunity Board in Las Vegas to support obstetric services for underserved women, and with them ensure Medicaid referral. The Bureau programs continue to support Medicaid outreach workers in the hospitals and the primary care offices. As the Bureau is primarily now a referral source (no longer having the direct services Special Children's Clinics) it no longer works so closely with EPSDT which is used to get authorization for services in the Clinics. The Bureau will work with DHCFP through the Real Choices grant to increase EPSDT usage by Medicaid children.

/2005/ The Bureau has a contract with Nevada's Division of Health Care Financing and Policy (Medicaid) to provide public education through the Maternal and Child Health Campaign about the importance of early and continuous prenatal care, other pregnancy related issues and infant care. Pregnant women and infants and children are also informed about the Medicaid and Nevada Check Up programs and referred to the programs if indicated. In addition, the Real Choice Systems Change project is working with Medicaid and Nevada Check up staff on an outreach campaign to sign children up for Medicaid and Nevada Check Up, and perform outreach for CSHCN services at the same time. A contract is in development for this project. //2005//

The CSHCN program also uses SSI for a referral. Program regulations require a denial from Medicaid, SSI, and Nevada Check Up for those children whose family income and for SSI the child's condition appear to meet those eligibility criteria.

Through the various programs in the Bureau the Bureau has contact with all the birthing facilities in the State. It works with them on issues such as newborn screening, newborn hearing screening, the Birth Defects Registry, and the Prenatal campaign. /2004/ The MCHAB has a Subcommittee looking at revising the NAC on NICUs; all the Level III and a few Level II nurseries have representatives on that Subcommittee. This revision is a joint project of the Bureau and BLC. //2004// ***/2005/ The NICU regulations were updated in 2004. //2005//***

/2004/ Along with moving all Early Intervention Services to the SHD, the Director also moved the Head Start State Collaboration to the Welfare Division with the Child Care Unit. //2004// The Bureau has representation on both the Head Start State Collaboration and the DHR Child Care Advisory Committee and ensures that health needs including those of CSHCN are part of every discussion of services. Both the Head Start State Collaboration and DHR Child Care Advisory Committee have similar memberships and frequently have similar agendas items.

The National Training Institute for Child Care Health Consultants:

The Bureau has teamed with the University of Nevada Reno (UNR) Cooperative Extension Services, the Children's Cabinet in Northern Nevada and the Economic Opportunity Board of Southern Nevada to obtain training for a team of four people at the University of North Carolina Chapel Hill on Child Care Health Consulting. This was a four-month program whose goal was to "train the trainer". The goal as a Child Care Health Consultant trainer is to educate the Child Care Health Consultants to adopt a comprehensive picture of the child care environment so that s/he will see that each component of healthy development - health, safety, social behavior, and intellectual skills, - is equally important, and no one component stands in isolation. Instead, all elements are interdependent, acting in concert to provide children with healthy, safe, and developmentally appropriate social, emotional, intellectual, and physical stimulation. Another goal is to create a link between health care providers and the child care community.

The team had both didactic and clinic training in all aspects of child health care and safety within a child care setting. This team will now train selected child care health consultants to become knowledgeable about the many components of quality in child care and the realities of various child care settings. These selected health care providers will become health consultants to child care programs. This training has been made possible by a CISS grant received by UNR. Follow-up training

of child care health consultants will take place over the next two years.
Recently the team had a "roll-out" conference for various health and community organizations, in order to educate them to child care health consultant concepts. In addition, the team gave a presentation to child care providers at their annual state conference.

/2004/ The Bureau's MCH supported Perinatal Nurse Consultant is the SHD's member on this team. She continues with the training of the child care consultants. //2004//

/2005/As noted in III.B, the Child Care Health Consultant program is in transition due to lack of funding and loss of their lead Child Care Health Consultant trainer. The MCH funded member continues to be available to child care providers for consultation and to train staff in the prevention of illnesses within a child care setting. The Bureau's Early Childhood Comprehensive Systems program will be working to continue this program. Funding to send new trainers to the National Training Institute is needed, as well as a mechanism to have Child Care Health Consultants paid for their work. //2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

III F. Health Systems Capacity Indicators.

The Center for Health Data and Research (CHDR) has the primary responsibility for obtaining the data for this application, including that for the Health Systems Capacity Indicators (HSCI). They worked with Bureau staff to obtain the data that is not contained in the CHDR's data warehouse. The warehouse includes birth and death certificates, hospital discharge data, WIC, Medicaid encounters, census and demographic data, Trauma Registry, etc. and is able to produce must of the HSCI data through data linkages. There are currently over 45 databases in the CHDR data warehouse.

HSCI # 1 has seen a small decrease in the rate of children hospitalized for asthma. The SHD tried once again to get an asthma grant to fund a focused initiative but so far is unsuccessful. The BCH is the lead on this initiative, with the Bureau working with them. Nevada is a desert state with a lot of pollen, and a lot of dust stirred up during the ongoing building in Clark County; asthma is a major health problem in the state.

HSCI # 2 has seen a decrease. Medicaid managed care remained optional in the north, as there was only one Medicaid Managed Care organization operating there. Access to EPSDT and the EPSDT rate are a concern of DHCFP. In FY03 Medicaid continued to partner with the Bureau in Baby Your Baby, which was a referral source for Medicaid (and Nevada Check Up) and referral to pediatricians and Family Practice doctors who would see children covered by Medicaid as well as have a sliding fee scale. Access to care is an issue for this indicator.

HSCI # 3 has seen a significant decrease. This could perhaps be attributed to work on DHCFP's development of a new MMIS system, and problems with getting reports out of the old one. It is a challenge every year to obtain the data for this measure as well as HSCI # 2. The Real Choice Systems Change project is partnering with Nevada's Covering Kids project (for Medicaid and Nevada Check UP outreach) to promote access to care for all children including CSHCN.

HSCI # 4, after years of steady increase, saw a decrease in FY03. As noted in III.B., Agency Capacity, the State Health Division withdrew from BYB in December, 2003, and instituted the Maternal and Chld Health Campaign. This prenatal campaign targets high risk populations to encourge early and continuous prenatal care. It also serves as a referral source for Medicaid and Nevada Check Up. It will also provide funding to support the provision of prenatal care for underserved women that will include ancillary services such as transportation, referral to substance abuse treatment, screening and provision of assistance for domestic violence, etc.

The data in HSCI # 7 as with HSCI # 2 indicates the continued need to perform outreach for Medicaid.

The Bureau's Oral Health Program is partnering with Medicaid to recruit dentists who will serve the underserved, including Medicaid clients, which are mainly children as Nevada Medicaid covers only emergencies for adults. The Primary Care Development Center continues to recommend Dental HPSAs, which makes communities eligible for dentists who can get licenses to serve in them without taking the state's dental exam.

HSCI # 8. The percent of SSI beneficiaries receiving services from CSHCN fluctuates from year to year depending on how many children are served by Early Intervention and other factors. The only children served by both SSI and CSHCN are those seen in Early Intervention and in the specialty clinics. This number comes from the estimated number of children served by Early Intervention who are on SSI (numerator) and the number of children total on SSI for CY 03 (denominator).

Form 18. This data comes from the CHDR. As has been noted in this section and in the report on Performance Measures, the Bureau continues to partner with Medicaid on outreach and getting women early and continuously to prenatal care, and infants born at Level III hospitals if they are at-risk.

Form 19. The Bureau was the applicant in a grant application to MCHB for HRSA CFDA #93.110W regarding "State Systems Development Initiative", which ended in FFY 03. The intent of the application was improve Nevada MCH's data capacity by linking databases to track health status indicators and continue to add databases to the SHD interactive web-based database initiated through the Maternal and Child Health Internet-Query Module (MatCHIIM) and INPHO the prior years. This project supports the activities of the CHDR.

The SSDI grants have addressed and continue to support the data linkages in the CHDR.
SSDI supported the linking of the following databases:
a. Infant birth
b. Infant death
c. WIC eligibility
d. Newborn screening
e. Birth defects registry
f. Medicaid and Nevada Check Up (S-CHIP) eligibility
claims
g. Hospital discharge

The CHDR is headed by Wei Yang, MD, Ph.D., Biostatistician.

A noted before, Nevada's Birth Defects Registry (BDR) is currently a "passive" registry, collecting information off of birth certificates. Funding from CDC enabled the collection of a full year (2001) of statewide "active" birth defects collection, giving the state a base year. A database was established for the BDR, which is housed in CHDR along with the Newborn Screening database. The 2003 Legislature directed the increase of the state's newborn screening fee to enable the establishment again of an "active" BDR. This regulation change was approved by the State Board of Health in September 2003; revenue had to accrue through FY04 before an FTE could be hired effective July 1, 2004. The Bureau is currently recruiting for an FTE who will be charged with re-implementing an "active" collection BDR. This FTE will be based in Las Vegas. This system will become part of the CHDR data warehouse.

In the past the SHD has done a PRAMs-like survey of recent mothers through the BYB program. This ability is no longer available due to confidentiality laws, which limit the use of birth certificate data in NRS. The Bureau is investigating other ways to get this information.

The State Department of Education conducts the Youth Risk Behavior Survey along with the Safe and Drug Free School Survey. It is given to middle and high school students, with some of the questions not appropriate for middle-schoolers left off the questionnaires distributed to them. Nevada is one of the few states that has weighted data so that each school district can have data that is weighted for its

local use. The State Department of Education has given the 2003 YRBS database to the CHDR and it is available on their website.

The CHDR does not have electronic access to the Pediatric Nutrition Surveillance System (which is collected on WIC clients). This data is sent to CDC for analysis.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Nevada's priorities and initiatives are based on the MCH Five-Year Needs Assessments completed in February 1996 and 2000 and updated. Key features of the Year 2000 Needs Assessment included the development of a "core group" whose membership included the Project Director, Project Coordinator, the MCH Chief, the Chief of Health Planning and Statistics, the State Biostatistician, and representatives from the Washoe County District Health Department and Clark County Health District. The core group was charged with reviewing the Year 2000 Needs Assessment outline, assisting the project coordinator with additional data collection, and making suggestions or additions to the final product. "Workgroups" were established to publicly discuss the inadequacies and inequalities among the 3 MCH populations in Nevada (pregnant women and infants, children and adolescents, and CSHCN). The workgroups were a tool to build bridges among traditional and non-traditional partners in the community; they were a primary source of information that helped shape the foundation of the Year 2000 Needs Assessment. In addition, two surveys and one focus group were held for CSHCN to ensure parent input. Primary and Secondary data sources were utilized. Presentations were also made to the Maternal and Child Health Advisory Board and the Governor's Youth Advisory Council, and a statewide videoconferenced public hearing was held to discuss preliminary findings and shape the final outcomes of the Needs Assessment. The persons involved in the Year 2000 Needs Assessment were very vocal, creative, and mindful of the populations they serve.

The priorities identified by the Year 2000 Needs Assessment include:

An overarching approach to Nevada's priority needs identified below, continues to be to identify ethnic, gender and age demographics of targeted populations, and use culturally appropriate assumptions and strategies to design and implement initiatives.

1. The teen pregnancy rates, particularly those of minorities, should be reduced.
2. The use of tobacco, alcohol, marijuana and other drugs among adolescents should be reduced.
3. The rate of child abuse and neglect should be reduced.
4. The incidence of Fetal Alcohol Syndrome should be reduced.
5. All women should have access to prenatal and postpartum services, which include medical and dental care, regardless of ability to pay.
6. The incidence of low and very low birthweight babies should be reduced.
7. Children with Special Health Care Needs in the state should have access to specialty and subspecialty services, including care coordination.
8. Children with Special Health Care Needs in the state should have access to quality day care, baby sitting and pre-school services.
9. The incidence of Early Childhood Caries in Nevada's children should be reduced.
10. Every child in Nevada ages zero to twenty-one should have a home for primary care, including dental care.

Ten State Performance Measures were developed from the ten priorities. Nevada elected in 2002 to change the wording somewhat for one performance measure (SP11) to better reflect data that is measurable. In addition, State Performance Measures 13 and 15 were deleted as there is no identifiable data source currently in the state for these measures. They remain a concern of Nevada's MCH Program, but as a numerator and denominator cannot be established they will not be an official State Performance Measure at this time. The eight are:

SPM 11. The percent of domestic violence screening among women of child-bearing age and their children should be increased. /2002/ The percent of women of child-bearing age who need assistance and receive it for domestic violence from an agency or shelter should be increased. (Population-Based Services, a risk factor)

SPM 12.The percent of women, children, and youth (ages birth to 21) who have access to preventive oral services and dental care, regardless of ability to pay, should be increased (Enabling Services,

capacity building)

SPM14. The rate of child abuse and neglect should be reduced (Population-Based Services, a risk factor)

SPM 16. Teen pregnancy rates among adolescents 15-19 should be reduced, with emphasis on minority populations (Population-Based Services, a risk factor)

SPM 17. Access to specialty and subspecialty services available to CSHCN should be increased (Enabling Services, capacity building)

SPM 18. Access to enabling services that assist CSHCN in care coordination, respite care, outreach, transportation, case management, and coordination with Medicaid, Nevada Check Up or purchase of health insurance should be increased (Enabling Services, capacity building)

SPM 19. The percent of children and youth (ages zero to twenty one) and women of child-bearing age who have homes for primary medical care, regardless of ability to pay, should be increased (Population Based Services, capacity building)

SPM 20 The percent of children and youth (ages zero to twenty one), women of child-bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased (Enabling Services, capacity building)

Outcome Measures (OM)one through five lead to the issue of achieving a healthy pregnancy and birth outcome. For FY05, the primary efforts of the MCH Program on achieving healthy birth outcomes will continue to be achieved through the Bureau's MCH Perinatal Program and Child and Adolescent Health Programs. Through the MCH Campaign, low-income, high-risk pregnant women, targeting African American and Hispanic women,will be seen by contracted community agencies not only for their obstetrical care, but for referral to appropriate social services. A mass-media campaign will educate all Nevadan's about the need for early and continuous prenatal care, good nutrition during pregnancy and the need for small children to have a "medical home". In addition, both health care providers and the public are educated about SIDS, Shaken Baby Syndrome, folic acid, oral health and other important issues. Oral Health with its potential link to low birth weight will continue to target pregnant women. Teen pregnancy prevention remains a priority.

For OM 6 the partnerships of Injury Prevention will work together to address preventing the deaths of children aged 1-14. The Bureau's Injury Data Surveillance Project produced "An Analysis of the Injury Surveillance Data System in Nevada" in FY 04, which guides the Injury Prevention initiative. The domestic violence and child abuse and neglect activities such as P.A.N.D.A. will continue.

B. STATE PRIORITIES

IV.B. State Priorities

Much of what could be said in this section including a list of priorities and SPMs is included in IV.A., Background and Overview. The resources of Nevada to address priority needs and National and State Performance measures relie heavily on partnerships with public and private entities. These partnerships and activities are described in IV. C. National Performance Measures and IV.D. State Performance Measures.

The Year 2000 Needs Assessment highlighted glaring deficiencies for the MCH populations that cut across all age, ethnic, racial, etc., groups. These three are oral/dental health care; mental health services; and access to primary care services. To date the Bureau's resources address oral/dental health care and access to primary care services, and very minimally access to mental health services.

Historically the 30% required of Title V block funds for CSHCN funds has gone primarily to Early Intervention services, which are direct services targeting the birth to three population. They also support two staff who are in the CSHCN office who handle the CSHCN applications and provide some case management, referral, and assistance with third party payors including Medicaid and Nevada Check Up to those both applying and those eligible for the CSHCN program. In FY05 the additional funds available for CSHCN will go to build the activities of the Real Choice Systems Change initiative into the Bureau's infrastructure, primarily by moving funding of staff from the RCSC grant to the Title V MCH grant. The Real Choice Systems Change grant from CMS supports systems development for CSHCN, including access to specialists and sub specialists, with pilot projects north, south and rural. It is discussed elsewhere in this document.

Newborn screening fees support the laboratory that performs the tests, the CSHCN Manager, specialty registered dietitians who operate out of the Early Intervention facilities north and south, and the metabolic specialist who comes under contract to the state. As previously noted, starting July 1, 2004, they will support an active Birth Defects Registry and its activities. The Newborn Hearing grant from MCHB supports systems development around that issue. These address NPM #s 1 through 6, and 12 and SPM #s 17 and 18 as well as 19 and 20. Discussions under those measures provide more detail on activities planned.

The 30% required of Title V Block Grant funds for Children and Adolescents go primarily to the fund the Child and Adolescent Coordinator, contracts with Washoe County District Health Department and Clark County Health District for adolescent medical clinics in Reno and Las Vegas, participation in the development of child care standards for health, oral health (primarily the sealant initiative), and teen pregnancy prevention. Together they promote the health and well-being of Nevada's youth, but Nevada recognizes this is a place where more resources should be addressed. The additional MCH Block Grant funding the state is receiving targeted to Children and Adolescents will support staff to work on an initiative for children from six to ten, a population that has been largely ignored in state initiatives. Other resources include the CDC Oral Health, Injury Prevention and Rape prevention grants, MCHB's Abstinence-only grant and Early Childhood Systems Development grants, the Primary Care Grant from the Bureau of Primary Health Care, and the WIC grant from the United States Department of Agriculture. These resources address NPMs # 8, 9, 10, 11, 13, 14, and 16, and SPMs # 12, 14, 16, 19 and 20. These are also discussed in the following sections.

In order to promote healthy birth outcomes in the state, the Bureau will be revamping some of its programs. Utilizing money from the MCH Prenatal Program and the Baby Your Baby campaign, a new program, the Maternal and Child Health Campaign (also noted in IV. A), will contract with community direct service providers to offer prenatal care, and a multi-media campaign will educate Nevadans about important maternal and child health issues. The Bureau has a contract with Medicaid to match the funds used for the educational portion of the campaign. The existing contract with Washoe County District Health Department and the Economic Opportunity Board in Clark County will be terminated after one more year (pending Legislative approval) and plans are to issue an RFP to contract those funds to community agencies also.

The Bureau conducts ongoing campaigns to educate the public about folic acid intake, the prevention of sudden infant death syndrome (SIDS) and shaken baby syndrome. All agencies contracted with the Bureau for maternal and child health services must screen their clients for domestic violence and refer to social services agencies or shelters as indicated. In addition, the Bureau has a Perinatal Substance Abuse Prevention program that partners with community agencies and private businesses to educate pregnant women about the importance of not drinking during pregnancy, as well as discouraging the use of tobacco and other drugs.

Nevada, as a state, in the past has received one of the lowest MCH Block Grants in the Nation, at $1,587,216 for a population of over 2 million. This year it has an increase to $1,996,035, which helps. What is received is distributed into four budget accounts through Legislative action, including targeting a large portion of the block grant to direct services, particularly for CSHCN in Early Intervention. Nevada is the fastest growing state in the Nation and has been for several years, and has some of the

worst health outcomes in the Nation, although this is changing. Put all this together and the only way Nevada's MCH Program can accomplish system and program development is through public and private partnerships and successfully seeking other grant funding. While all of the SPMs have programs and activities to address them, this is not true of all of the NPMs where Nevada can report on them but the MCH program does not have the resources to address them in any but the most peripheral way.

The State has received $414,494 more in block grant funding. This additional funding is going to identified priorities (not direct services), including the MCH Campaign to promote healthy birth outcomes, CSHCN systems development, and child and adolescent services targeting young children (all discussed throughout this document). In addition many of the current initiatives around the priorities are funded with grants and other sources including state general fund. This will enable activities that lead to sustainability when grants and other sources end.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

NPM 1: FY 03: 99.6%

The data source for this measure is state CSHCN Newborn Screening database and birth certificates. This measure is both direct services and population based.

Nevada has contracted with the Oregon Public Health Laboratory (OPHL - a regional laboratory) to do its newborn screening since the early 1970's. OPHL and contracting state agencies developed a tracking and follow-up system that is one of the leaders in the newborn screening community. Protocols and educational materials have been developed, and brochures and practitioner manuals are distributed statewide. OPHL also provides specialty consultation to the laboratory through a contract with the Oregon Health Sciences University, and to primary care providers (PCP's) in Nevada for confirmatory testing and the initiation of treatment. The SHD contracted with a metabolic geneticist to provide ongoing clinical consultation in Nevada to individuals who have been diagnosed with a metabolic disorder. The specialist saw infants, children and adults, and Early Intervention clinics (EI) registered dieticians, who have received special training in the treatment of these rare disorders, provided nutrition consultation. The specialist and dieticians offer not only medical management of the disorder, but also counseling relative to the importance of initiation of the special diet prior to becoming pregnant. In the last few years, females with metabolic disorders who wish to become pregnant have returned to the clinic for specialist and dietician services prior to and throughout their pregnancy. Finally, the CSHCN program paid for medical specialty foods for eligible children such as those with PKU and worked to ensure all CSHCN with metabolic disorders received the services they need.

b. Current Activities

b. Current Activities
NPM 1: FY04 Nevada continues to have one of the top programs for Newborn Screening in the nation. From year to year, 98-99% of Nevada's newborns are screened for PKU, Galactosemia, Hypothyroidism and Hemoglobinopathies, as well as for Biotinidase deficiency and Maple Syrup Urine Disease. In addition, 86-88% of newborns receive a second confirmatory screening. In FY 04 Nevada renewed its contract with OPHL to provide expanded testing of infants using Tandem Mass Spectrometry which can detect additional metabolic, amino acid,

organic acid and fatty acid disorders. In addition, testing for congenital adrenal hyperplasia was added to the panel. A fee increase, which has to be approved by the State Board of Health, was required to provide the needed funding. In September 2003 the Nevada State Board of Health approved an increase that also supports a full time employee for the "active" component of the Nevada Birth Defects Registry. The implementation of "expanded" testing has increased the number and intensity of follow-up activities for staff, and has also provided an additional element of quality to Nevada's already successful program. Data is obtained through State vital statistics (birth certificates) and Newborn Screening records. Note: this measure reports screening for all newborns born in the State, regardless of state of residency. There is no data at this time available on newborn screening for those resident infants born out of State.

The SHD contracts with a Metabolic Geneticist to come to the state on a regular basis to see children with inborn errors of metabolism and women of child-bearing age with the same who are considering getting pregnant. Individuals are seen by the clinical Metabolic Geneticist at the E.I. clinic, where they receive not only Geneticist consults, but ongoing access to registered dieticians who have special training in managing these disorders. The Metabolic Geneticist will also consult by phone with any physician in the state with a metabolic question; this consultation is a provision of the contract.

The CSHCN program covers special formula and special foods to those individuals who meet program eligibility requirements.

Those individuals who are detected by the program as having a possible metabolic, thyroid or hemoglobin disorder are referred to the Metabolic Geneticist, Endocrinologist, or Hematologist for confirmatory testing and ongoing treatment if necessary. The child is automatically referred to the CSHCN program for continued follow-up services. The CSHCN program provides appropriate referral to a variety of resources and maintains a "registry" of infants found to have a disorder detected by the NBS program. The registry triggers an annual update with the family to determine if the family's status has changed and to assure that the child is still receiving necessary services.

c. Plan for the Coming Year

c. Plan for the Coming Year
NPM 1: FY05. A new laboratory contract was in place as of July 2003. OPHL will provide "expanded" Tandem Mass Spectrometry testing for amino acid, urea cycle. Screening for organic academia and fatty acid oxidation disorders, in addition to the current panel, as well as screening for Congenital Adrenal Hyperplasia have also been added. This program will provide "state of the art" testing for twenty-five disorders to Nevada's successful program. Two specimens will continue to be taken to assure no "missed" cases. When additional information regarding the specificity of the new methodology becomes available, Nevada will evaluate the necessity of two specimens at that time.

The SHD will continue to contract with a Metabolic Geneticist to provide ongoing clinical consultation to children born with metabolic disorders and women of childbearing age with PKU and other metabolic conditions that want to have children. The Metabolic Geneticist will also consult by phone with any physician in the state with a metabolic question; this consultation is a provision of the contract.

All infants detected with an inborn error of metabolism, endocrine or hemoglobin disorder will continue to be automatically referred to the Children with Special Health Care Needs (CSHCN) program for coverage of needed physician, laboratory and nutrition services. MCH funded nutritionists based in the Early Intervention clinic will continue to provide ongoing nutrition guidance to metabolic cases and the program

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

a. Last Year's Accomplishments

NPM 2: FY03 54.6%

Data Source: Summary Tables from the National Survey of Children with Special Health Care Needs, 2001. This measure is enabling.

This is an area in which MCH has had little influence in the past, but renewed efforts to increase family participation had much success. A new partnership with Family Ties promoted family participation in the State CSHCN program. A Real Choice Systems Change grant was awarded to Nevada as a result of a renewed statewide interest in developing a more "seamless" system of services and support for CSHCN but did not really get active until FY 04.

The Early Intervention clinics (formerly known as the Special Children's Clinics), have had organized family support groups within the clinics for some time. These groups offer parents an opportunity to share their experiences with each other, and also explore different modes of solving problems. Staff members are available as both a resource and a participant to help resolve problems - especially those encountered with staff and/or " the system".

Resource Parents in the clinics provided valuable input into the functioning of the clinics, and acted as liaisons with other parents on an as-needed basis. The Resource Parent in Reno, for example, was instrumental in organizing parents into a 501-C (3) non-profit organization called "Friends of Special Children". Friends of Special Children have been very active in assisting with the development of a multidisciplinary diabetes clinic in Reno, and Natural Environment day care options.

b. Current Activities

NPM 2: FY04. Bureau staff continues to participate in parent empowerment programs sponsored by the Family Ties organization regarding "navigating the benefits system". Grass roots organizations collaborated to promote improved systems statewide, and influenced community agencies to collaborate on a formal plan for the state. For example, the CARES foundation, a family support and advocacy group of parents whose children have congenital hyperplasia, successfully campaigned in September 2003 with the State Board of Health to gain approval of funding for recommended enhancements to the state Newborn Screening program discussed in NPM 1.

Family Ties staff is participating in the Bureau's MCH Needs assessment and continues to interact with program staff. CSHCN and RCSC staff attended a Family Ties regional meeting to discuss ways to more forward to meet the needs of special needs children. The meeting clarified areas in which families become frustrated within state systems, and helped in identifying areas of state systems that need improvement. This open exchange helped each side to gain a greater understanding of the other's situation and gain insights into how to best achieve goals that work for both.

The Bureau works with parent and advocacy groups such as "Nevada Dual Sensory Impairment Project", to discuss available programs and accessing services within the community. Activities have included meetings and panel discussions with consumers in both Reno and Las Vegas to discuss the scope of services covered by Title V programs, as well as developing linkages with other agencies such as Medicaid, Nevada Check Up, Shriner's and the Department of Education, for access to, and coordination of services. The meetings

included a cross section of consumers, many of whom are adults with disabilities, as well as the parents and foster parents of children who have a variety of disabilities and needs.

The SHD was awarded a Centers for Medicare and Medicaid Services "Real Choice Systems Change" grant that provides needed resources to assess and assure family participation in decision making for CSHCN. A program manager, a management analyst, and clerical support were hired and immediately moved forward in putting out a "Request for Proposal" for a contractor to perform a statewide needs assessment of the strengths, weaknesses and gaps in service in Nevada's system of care for CSHCN. The Family Ties representative was a part of the evaluation team. The RCSC grant staff have been active in partnering with groups such as Medicaid's Continuum of Care office, Mental Health, E.I.Services, Office of Disability Services, Vocational Rehabilitation, Department of Education - Special Education, the Transition Forum - a subcommittee of the Governor's task force and County School Districts. All of these agencies and consumers were involved in the development of the Real Systems Change grant application, and continue to be involved as it is implemented.

c. Plan for the Coming Year

NPM #2: FY05. Plans are to strengthen existing relationships with Family Ties and Early Intervention Services and continue to collaborate with the new partners in the office of Disability Services, Mental Health, Special Education and the County School Districts. These established and new links will be active participants in the RCSC grant needs assessment. Activities directed toward linking Family Ties representatives and E.I. staff will also continue. The Bureau staff will continue to work on establishing Family Ties representation at the E.I. clinics to better empower families in choosing appropriate services for their child. They will partner with the Resource Parents already in place. Family Ties and CSHCN staff will continue to provide cross referral for services. Family Ties information and referrals forms will continue to be sent to families applying for CSHCN, and Family Ties readily refers to CSHCN.

The Nevada Advisory Council on CSHCN will meet, and advise the CSHCN program on program development. The RCSC Needs Assessment will be completed and will form the basis for three pilot projects (funded by the RCSC grant) for systems change for CSHCN; the Council will be very involved in their development and oversee their implementation.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

a. Last Year's Accomplishments

NPM 3: FY03: 49.1%

Data Source: Summary Table from the National Survey of Children with Special Health Care Needs, 2001. This measure is enabling.

Based on the SLAITS data, 49.1% of CSHCN statewide have a medical home. This is an change from years past, when the State could only report on those children served by the CSHCN program. The CSHCN program has policies in place that encourage a child to have a primary care provider (PCP). Children enrolled in the CSHCN program receive assistance in finding a PCP if they do not have one. The program reimburses PCP's for quarterly visits for care for the eligible condition. CSHCN are only required to be seen by the pediatric sub-specialist once a year if the condition is stable. This policy has encouraged families to find a PCP, and also has made more PCP's willing to participate in the care of CSHCN. In the past, only paying for specialist services disrupted the ongoing relationship with the PCP and encouraged them to "hand over" care to the specialist. Now, the program recognizes the

importance of the PCP and allows them to decide when the patient needs to be seen by the specialist,thus encouraging increased interest and case management.

b. Current Activities

NPM 3. FY 04. At this time the Nevada CSHCN program can only specifically track and analyze the status of those CSHCN who are either eligible for assistance with payment of their treatment and other services, an/or seen at the multidisciplinary medical specialty clinics.

The CSHCN program encourages families to have a "medical home" or "primary care provider" (PCP). Families are asked who the child's PCP is, and the program will cover quarterly visits to the PCP if the child's condition remains stable,however, the program does still require at least an annual visit with the sub-specialist. Since most of the PCP's for this population are Board Certified Pediatricians, they have embraced this policy and have willingly assumed this responsibility as it has enhanced their ability to see the patient on a continued basis. If a family does not have a PCP, staff works with the family to find an appropriate PCP. PCP's often call CSHCN staff to seek assistance with accessing needed resources. CSHCN staff monitor cases for Medicaid and Nevada Check Up eligibility.

Medicaid and Nevada Check Up programs mandate managed care in the urban areas of the state. In FY 04 a second HMO was added in the north, so managed care is mandated there now too. A majority of CSHCN on these programs should have a medical home.

The BYB pediatric campaign was also a source of information. It ended on December 31, 2003, and was replaced by the MCH Campaign. Its multi-media component encourages families to seek a medical home for their children and provide public health education on the value of primary and preventive care. Callers to the IRL for pediatric information are referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the MCH campaign have also agreed to see infants and children regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients. The Pediatric Campaign sees a steady increase each year in the number of callers to the IRL. The MCH campaign continues a Pediatric outreach campaign as it was in BYB.

The Real Choice Systems Change needs assessment will include a look at what services are available for primary, mental and dental care for CSHCN, and where gaps are. It will also look at access to pediatric specialists. This will help with the planning for the pilot projects in FY05.

c. Plan for the Coming Year

c. Plan for the Coming Year
NPM #. FY05. A goal of the Real Choice Systems Change grant is to increase the E.P.S.D.T. rate for CSHCN on Medicaid. Staff will work with Medicaid and Nevada Check Up to develop ways of increasing the number of children eligible for and receiving these preventive examinations. The Real Choice Systems Change grant will provide needed support to identify data sources that expand to all children, and provide state planners with useful information to determine where increased efforts need to be focused.

A goal of the Real Choice Systems Change grant is to ensure a medical home for all CSHCN in Nevada. As noted in FY 04 the needs assessment will establish resources and gaps in primary, mental and dental care as well as specialty care that the pilot projects will address.

The MCH Campaign is also a source of information for families. The multi-media component encourages families to seek a medical home for their children and provides public health education on the value of primary and preventive care. The multi-media campaign is using

Bright Futures to guide the content of the multi-media campaign. Callers to the IRL for pediatric information will continue to be referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the MCH Campaign have also agreed to continue to see children, including infants, regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients.

The CSHCN program will continue to establish and cover a PCP for those children who are on the program.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

a. Last Year's Accomplishments

NPM 4. FY03 : 55.4 %
Data Source: Summary: Table from the National Survey of Children with Special Health Care Needs, 2001. This measure is population based.

CSHCN staff assisted families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs. Assistance through the process and advocacy for services coverage was also provided to those with private insurance, as well as government programs. CSHCN staff also provide advocacy for families with private insurance in providing medical information, especially for rare disorders, in order to justify the need for specific services and supplies. This has aided families in receiving previously denied services, and also in accessing medically appropriate services for their child.

The CSHCN program was of great benefit to these families in that it not only capped the amount of payment for services, but helped families meet requires deductibles and co-payments. This was of great assistance to those families facing high medical costs for specialty services needed by their child. CSHCN who could not receive Nevada Check Up due to their insurance status were (and are) eligible for CSHCN. The CSHCN Program worked with Nevada Check Up to promote referrals for these children.

b. Current Activities

NPM 4. FY04 HD staff worked with staff from Medicaid and Nevada Check Up (SCHIP) to more clearly identify CSHCN in all programs. This increased awareness of the need for identifying children with special needs throughout the state has encouraged closer cooperation between agencies and enhanced sharing of available data.

CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information, referral and assistance through the process. CSHCN staff also provide advocacy for families with private insurance in providing medical information, especially for rare disorders, in order to justify the need for specific services and supplies.

The MCH information line (formerly the IRL of BYB) has been a primary component for signing up infants and children for Medicaid and Nevada Check Up. All who call are queried regarding their insurance status. If they do not have or have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of Great Basin Primary Care Association (GBPCA). The CSHCN program also is a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The Real Choice Project Team is collaborating with the Covering Kids program for a joint media campaign in association with the Nevada Broadcaster's Association (NBA). Covering Kids is a grant funded program housed in the Division of Health Care Financing and Policy (DHCFP). The program's goal is to reduce the number of uninsured children who are eligible for public health care coverage programs but not enrolled. The media campaign's goals will be to increase awareness of available state programs for all children, including those with special needs. The campaign will also promote the Healthy Kids (EPSDT) program and the services available through the CSHCN program. The campaign will be guided by a contracted media professional who is also Nevada's Family Voices coordinator and director of Family TIES, a parent-driven group which provides training, information, and emotional support for CSHCN and their families.

c. Plan for the Coming Year

NPM 4. FY 05. CSHCN staff will continue to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources. Assistance through the process and advocacy for service coverage will also be provided to those with private insurance, as well as government programs. CSHCN staff will continue to provide advocacy for families with private insurance in providing medical information, especially for rare disorders, in order to justify the need for specific services and supplies. CSHCN staff will continue to refer potentially eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made.

The MCH information line (formerly the IRL of BYB) will continue to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers are queried regarding their insurance status. If they do not have coverage, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of Great Basin Primary Care Association (GBPCA). The MCH information line and the CSHCN program will continue as a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The CSHCN program will work with Nevada Medicaid and Nevada Check Up to increase the number of CSHCN who receive an E.P.S.D.T. examination for their child. Since Medicaid already tracks this data, CSHCN will request an annual report. CSHCN staff will continue to work with Nevada Check Up to develop a means of tracking this type of data in their program.

The Bureau will watch very closely what happens to eligilbity to Medicaid after the asset test is dropped on July 1, 2004. It is anticipated that it could have some impact on the CSHCN program if more children are made eligible for Medicaid with this change.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

a. Last Year's Accomplishments

NPM 5. FY 03: 75.1%
Data source: Summary Table from the National Survey of Children with Special Health Care Needs, 2001. This is a population based measure.

CSHCN staff provided information and advocacy to families and providers attempting to access community-based services. CSHCN staff maintains current information regarding eligibility criteria, asset test criteria, and medical criteria for a variety of programs including Medicaid, SCHIP, food stamps, WIC, federally qualified clinics, mental health services, and community

organizations. This allows them to serve as a 'data bank' of information for families in need of high quality, but often expensive, medical care. CSHCN staff also maintains contact with organizations such as the Shriner's in order to provide appropriate referrals and assist with ancillary services as needed. Staff continually update lists of local providers of pharmacy, durable medical equipment, supplies and transportation to assist families with needed services, and has been actively involved with arranging for connecting families with appropriate volunteer organizations to receive assistance with "uncovered" services such as lodging, transportation, and "new types of equipment" that are often not covered by most insurance. Staff also provides training to parent groups to assist them in accessing programs and services.

Historically, and in FY 03, case management services were provided for CSHCN through the E.I. multidisciplinary specialty clinics, and for seriously involved cases in the CSHCN Program clientele. In FY03, the Special Children's Clinics were part of the Bureau of Family Health Services at the SHD and the rural and some urban early intervention services were under the jurisdiction of the Division of Child and Family Services. (In FY 04 these were combined into a new Bureau under the auspices of the State Health Division. Reorganization of the Early Intervention Services into a new Bureau in the Health Division provided a new opportunity for the CSHCN Program to interact with all aspects of early intervention services statewide in a central administration, and within the same Division.)

All CSHCN program eligible cases received care coordination services that included information/referral, advocacy services for insurance coverage and program eligibility, and access to a variety of community resources. CSHCN had policies in place that required local specialist involvement in the referral process, thus assuring that the child had access to quality follow-up services locally - even if sub-specialist services were required out of state. Medicaid cases of CSHCN did not generally receive case management services, as many services were on a "fee for service" basis. This often resulted in patients going out of state for services and having no follow-up services available locally.

b. Current Activities

NPM 5. FY 04. CSHCN staff continues to provide information and advocacy to families and providers attempting to access community-based services. CSHCN staff maintains current information regarding eligibility criteria, asset test criteria, and medical criteria for a variety of programs including Medicaid, Nevada Check Up , food stamps, WIC, federally qualified clinics, mental health services, and community organizations. This allows them to serve as a 'data bank' of information for families in need of high quality, but often expensive, medical care. CSHCN staff also maintains contact with organizations such as the Shriner's in order to provide appropriate referrals and assist with ancillary services as needed. The CSHCN Program is collaborating with BEIS to develop improved procedures for referral and linkage to other government programs and community groups.

Staff continually update lists of local providers of pharmacy, durable medical equipment, supplies and transportation to assist families with needed services, and has been actively involved with arranging for connecting families with appropriate volunteer organizations to receive assistance with "uncovered" services such as lodging, transportation, and "new types of equipment" that are often not covered by most insurance. E.I interdisciplinary clinic staff provides a multi-disciplinary evaluation and referrals to appropriate medical, social and mental health services, as well as referrals for community programs including CSHCN.

Staff also provides training to parent groups to assist them in accessing programs and services. The Family Ties program conducts a parent training for families of CSHCN. CSHCN staff is consistently asked to participate and provide input to parents on how to best "navigate the system". This has proved to be a most satisfying experience on both sides. As a result, families and family organizations are initiating increased contact with CSHCN staff with requests for information.

Staff was hired for the Real Choice Systems Change grant and they immediately set about drafting a "Request for Proposal" for a statewide needs assessment. A vendor was chosen and work will begin this summer. RCSC staff has also connected with representatives of Medicaid, Nevada Check Up, E.I., Mental Health, Office of Disability Services, Vocational Rehabilitation, Department of Education-Special Education, and local County school districts.

c. Plan for the Coming Year

NPM 5. FY05. CSHCN staff will continue to provide information and advocacy to families and providers attempting to access community-based services. CSHCN staff continually maintains current lists of local providers for pharmacy, durable medical equipment, supplies and transportation to assist families with needed services. CSHCN will continue to maintain current lists of local volunteer organizations to access assistance with "uncovered" services such as lodging, transportation and "new types of equipment" that are often not covered by most insurance. CSHCN staff continually update information on eligibility criteria for Medicaid, Nevada Check Up, food stamps, WIC, Shriner's, federally qualified clinics, and community organizations in order to provide appropriate referrals and ancillary services as needed.

The SHD was awarded a "Real Choice Systems Change" (RCSC) grant by the Centers for Medicare and Medicaid. This funding is support a statewide needs assessment of the current systems of care for CSHCN which will be completed by January 2005. The RSSC grant supported needs assessment will provide a clear outline of gaps in service for CSHCN. State planners will be able to more clearly define areas of "non availability" or "non coverage" as well as those areas of the state lacking or duplicating services. Rural areas of the State will, of course, be among the most needy of services, but defining where and what services exist/or are needed, will be a real start in solving the problems. The Nevada Advisory Council on CSHCN that will be created with this grant support will formally bring together all those stakeholders involved with this population, and will allow for creative solutions to be developed. To attain the broadest degree of stakeholder involvement, the Council will include family members of CSHCN and disabilities advocates from across the state. The Council will review the needs assessment report and will help determine areas of priority and will have decision making authority in the direction and content of project activities. Staff will also develop a strategy for ensuring council involvement in the project during the project period and also in maintaining council involvement in issues affecting CSHCN in Nevada after the funded project activities have been completed.

There is an emerging network of parents and families of CSHCN, advocacy groups, and other stakeholders emerging in Nevada. The creation of the Nevada Advisory Council on CSHCN will strengthen coordination and linkages, and build on existing networks, whose mutual goal is to build an enduring improvement of community-based services and supports for CSHCN in Nevada.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

NPM # 6. The percentage of youth with Special Health Care Needs who received the services necessary to make transitions to all aspects of adult life. FY02: 5.8%
Data Source: Summary Table from the National Survey of CSHCN, 2001. This measure is population based.

NPM # 6, FY03. As a result of the poor progress with school districts, the SHD addressed this issue with the help of its collaboration with Family Ties, a parent organization. Staff participated in training sessions sponsored by family organizations. This has provided the opportunity to not only educate families about the importance of their input for the medical care of their children and how to access community resources, but also to suggest ways they can engage the schools in planning for the educational and training needs of their children for the future. Parents were advised of the importance of the individualized education plan (IEP) for their child, and how their input is vital to the planning for their child's future. This has resulted in parents understanding how they can be empowered by the knowledge they have about their child's needs and capabilities. It has also enabled parents to realistically plan for their child's move to adulthood in areas such as independent living, and residential care. It has also prompted parents to plan for the financial stability of their child.

b. Current Activities

NPM # 6. FY04. CSHCN staff, in collaboration with Family Ties, continued to provide information and advocacy for families to access federal, state and community organization assistance. CSHCN staff continued to counsel parents regarding having the PCP assist with referral to adult health care providers and ensuring the transfer of medical records. CSHCN staff and Family Ties representatives continued to provide information to parents regarding individualized education plans for appropriate vocational training of CSHCN, and encouraged families to be involved with the educational plan for their child.

The SHD was awarded a Real Choice Systems Change (RCSC) grant from the Centers for Medicare and Medicaid Services. The SHD is using this funding to hire a vendor to complete a needs assessment of Nevada's system of long term services and supports for CSHCN and their families by January 2005. Program staff will coordinate with the full and active participation of stakeholder groups and interests, including state and local agencies, public and private service providers, advocacy groups and networks, and parents and families during all phases of the project. Initially, to involve the broadest degree of stakeholder involvement, program staff will coordinate the establishment of a "Nevada Advisory Council on Children with Special Health Care Needs". This council will include family members of CSHCN and disabilities advocates from across the state that will be given decision-making authority in the direction and content of Nevada RCSC project activities. Included in the plan will be a strategy for ensuring council involvement in issues affecting CSHCN in Nevada after funded project activities have been complete.

The Real Choice project team began collaborating with the Transition Forum, a subcommittee of the Governor's Council on Rehabilitation and Employment of People With Disabilities. The RCSC project team also began working with county-level transition groups (specifically Washoe and Clark counties) and with advocacy groups like Nevada PEP (which assists parents of children with special health care needs in the IEP process) to assist them with both their goals and the goals of the RCSC and CSHCN teams. They are also collaborating with another Real Choice Systems Change grant which was awarded to the State Office of Disability Services in FY2003. An interlocal agreement was developed to coordinate the scopes of work for both Real Choice grants to best assist adolescents and young adults in their transition to all aspects of adult life, including education, employment, and housing.

c. Plan for the Coming Year

NPM # 6. FY05. The Real Choice Systems Change project team has begun work on CSHCN transition by contracting a vendor to perform a statewide needs assessment (to be completed by January 2005). The assessment will include focus groups consisting of families of CSHCN, as well as adolescents and young adults (ages 15-22) with special health care needs. An emphasis of this qualitative data collection will be the challenges faced by youth transitioning to adult life and services. The needs assessment will also identify all mental and other health care providers throughout the state and will result in the development of a true resource inventory for Nevada's CSHCN and their families.

The RCSC project team is also in the process of developing an interagency working group to bring all providers of services for the CSHCN population together. This group will include representation from BFHS CSHCN Program, Medicaid's Continuum of Care Office, Welfare, Nevada Check Up, DETR (Specifically Vocational Rehabilitation), the Bureau of Early Intervention Services, the Department of Education, and the Office of Disability Services. Transition supports and services will be a key topic of interest for this group, as well as for the Nevada Advisory Council for Children with Special Health Care Needs. Inclusion of state and county-level special education coordinators on the Advisory Council will be instrumental in addressing issues around transition.

The RCSC team, along with the CSHCN program and the Bureau of Early Intervention Services is working to augment the current central resource directory (Project ASSIST) and to make it available through the CSHCN webpage (which is currently in development). This resource will allow CSHCN, their families, advocates, and providers 24-hour access to a current database of available services and supports for all of Nevada's CHSCN. Many of these supports include transition as a major area of interest.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

a. Last Year's Accomplishments

NPM # 7. Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. FY 03 74.4%

Reporting of this measure is from the U.S. National Immunization Survey for Nevada for children born between August 1998 and November 2002. This goal is always impacted by the state's rapidly growing population and ever increasing birth rate. This measure is a population based service that targets infants and young children. Although this National Performance Measure is reported to age 35 months, the initiative itself serves older children including those to age 5 in the WIC program. A separate report, the Government performance and Results Act (GPRA) 2002 survey of Medicaid clients found 62%, indicating Medicaid children continue to be an underserved group that needs to be targeted for vaccination.

MCH funding supported immunizations offered in Bureau of Community Health community health nursing clinics as well as in MCH supported Washoe County District Health Department clinics.

There is a very strong link between Nevada's Immunization (IN BCH) and WIC programs. All WIC clinics routinely request WIC participants bring in their Immunization records as part of the WIC Certification and Recertification clinic visit. WIC staff review the Immunization records to determine if participants are current with the appropriate immunizations and refer to BCH or other appropriate provider if they are not. In the coming year, the WIC and Immunization

programs will work together to develop new links needed for the WIC Program in the Immunization Registry software. Once the links are in operation, the Nevada Immunization Program has agreed to provide training to the WIC clinics on how to access and use the new Immunization Registry. In the meantime, new WIC clinics are starting to be linked into the Nevada State Health Division network backbone using T-1 lines. Those WIC clinics with existing ISDN will be upgraded to T-1 lines in the future. This will provide smoother access to the Immunization Registry through the Health Division Intranet.

The Nevada WIC hot-line number (1-800-8 NEV WIC) is the number given for information with the Nevada Broadcaster's PSA campaign for immunizations. This is a bilingual line. The Nevada WIC Program and the Nevada Immunization program shared the cost of a joint marketing plan in selected areas of the State. WIC clients in Washoe County are also able to keep track of their immunizations by way of the Health Passport Project (HPP) smart-card, although very few have taken advantage of this opportunity. The smart-card project was launched in Washoe County in June 2000 and continued in FY04.

Prevnar and Hepatitis A are now part of Nevada's Vaccine for Children Program. Effective July 1, 2002, all students enrolling in Nevada schools had to have Hepatitis A and Hepatitis B.

b. Current Activities

NPM # 7: FY 04. Activities begun in FY 03 continued into FY 04. There is a very strong link between Nevada's Immunization (IN BCH) and WIC programs. All WIC clinics routinely request WIC participants bring in their Immunization records as part of the WIC Certification and Recertification clinic visit. WIC staff review the Immunization records to determine if participants are current with the appropriate immunizations. If participants are not current with their immunizations, they are referred to appropriate providers. As reported for FY 03, the effort to integrate the WIC clinics into the State immunization registry along with the Community Health Nurse Clinic sites, private providers, health districts, hospitals and some HMOs started in FY02, but a new obstacle was encountered which has held up this process. During the past year, the Nevada Immunization Program transferred the Immunization Registry to new software, rendering the old links obsolete and useless. In the coming year, the WIC program and the Immunization program will work together to develop the new links needed for the WIC Program in the Immunization Registry software. Once the links are in operation, the Nevada Immunization Program has agreed to provide training to the WIC clinics on how to access and use the new Immunization Registry.

In the meantime, the new WIC clinics are starting to be linked into the Nevada State Health Division network backbone using T-1 lines. Those WIC clinics with existing ISDN will be upgraded to T-1 lines in the future. This will provide smoother access to the Immunization Registry through the Health Division Intranet.

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MCH funding supports immunizations offered in the MCH supported BCH community health nursing clinics as well as in the MCH supported Washoe County District Health Department clinics.

Effective July 1, 2003, Varicella will be added to enrollment requirements for all Nevada schools. It is added to Prevnar and Hepatitis A, which were added July 1, 2002.

The Bureau maintains a MCH Information and Referral line, which is staffed by a bilingual

operator. Callers requesting information about immunizations are referred to local clinics that give immunizations in their area.

c. Plan for the Coming Year

NPM # 7: FY 05. Nevada's WIC program will complete the link with the State's Immunization Program within the Bureau of Community Health (BCH). All WIC clinics will be integrated into the State immunization registry along with the Community Health Nurse Clinic sites, private providers, health districts, hospitals and some HMOs. When completed this will allow for fewer missed opportunities since WIC clinics will have the ability to do real time searches of children's immunization records. Depending on the location of the WIC clinic, they are able to send a family to a nurse to obtain needed immunizations on site, or will refer the family to a site for immunizations. The Nevada WIC hot-line number (1-800-8 NEV WIC) is the number given for information with the Nevada Broadcaster's PSA campaign for immunizations. This is a bilingual line. The Nevada WIC Program and the Nevada Immunization program share the cost of a joint marketing plan in selected areas of the State. These activities and are planned to continue in FY05.

WIC clients in Washoe County are also able to keep track of their immunizations by way of the Health Passport Project (HPP) smart-card, although very few have taken advantage of this opportunity. A cost benefit analysis of the various options for the project was completed in July 2003 by an independent contractor. The final recommendation was to rollout the smart-card statewide. Additional funding was received from USDA to rollout the smart-card in Las Vegas, Nevada. This will increase the number participating in HPP to close to 75% of the WIC participants statewide. The project is facing some delay due to interoperability issues that are still being worked out, but the State hopes to roll out statewide by the end of 2006. The Health Passport Project received a strong endorsement from Richard Carmona, Surgeon General of the United States during his visit to Washoe County District Health Department in May 2004. Immunizations remain a priority for WIC nationally and in Nevada.

MCH funding will continue to support immunizations offered in the BCH community health nursing clinics as well as in the MCH supported Washoe County District Health Department clinics.

The SHD is in the midst of changing Nevada's universal vaccine distribution policy. Although many questions remain to be answered, it is anticipated in FY04 Nevada's immunization policy will no longer be universal but will target underserved populations. A CDC advisor has been requested to help the state assess its Immunization Program and its future. Nevada's MCH Program will continue to partner with the Immunization program in whatever iteration it is in.

The MCH Campaign will recognize immunization month as part of its media campaign.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

NPM # 8. The rate of birth (per 1,000) for teenagers aged 15 through 17 years. FY03: 27.5 per 1,000.

The data for FY 03 is from state birth certificates, CHDR database. This measure is population based.

Nevada maintained a multi-faceted approach to teen pregnancy. Using the Teen Pregnancy Action Plan as a guide, the State continued its aggressive strategies to spread the word on the

challenges of teen parenthood.

Abstinence-only funds were not made available to community organizations in FY03, but will be made available in FY04. This is because Congress still had not re-authorized funding for abstinence-only education. Some community organizations have remained active using funds from other sources and the State continued to support them with technical assistance.

The Bureau and Southern Nevada Area Health Education Center (AHEC) collaborated on providing training for parents in the various issues of teen maturation and how to talk to their children. The curriculum used is Positive Choices, Positive Futures (PCPF)- Helping Parents Help Teens. The program was marketed in Northern Nevada, with little interest. Only 2 presentations were executed in Northern Nevada in FY03. AHEC has been successful in marketing the program and has reached a large number of Hispanic families.

The State Partnership to Prevent Teen Pregnancy supervised an RFP process in FY02, resulting in the awarding of contracts to programs promoting teen pregnancy prevention. The contracts were awarded for a social marketing campaign and 5 local project grants. Ogilvy Public Relations Worldwide executed the media campaign in SFY03 with success. The local project grants were awarded August 2002, and continued through June 30, 2003. Two grant recipients focused their teen pregnancy prevention efforts on minority populations. The TANF funding was not available for another RFP process in FY04.

b. Current Activities

NPM # 8: FY04. The main activities for Nevada's teen pregnancy prevention initiative include community involvement through community organizations, the Nevada Statewide Coalition Partnership, which is a network of prevention coalitions located in ten of Nevada's seventeen counties, workshops for parents of adolescents, and the continuation of the Governor's Youth Advisory Council, which has identified teen pregnancy prevention as its top priority.

Due to Congress reallocating funds to the States based on Census 2000 data, Nevada is being given nearly double the Abstinence-Only funds in FY04 than FY03. The majority of the increased funding are being made available to the community organizations via an RFP process. These funds are targeted towards the Hispanic/Latino populations of Clark and Washoe counties which are the states most populous counties with the highest rates of teen pregnancy.

Some funds are also being used to promote parental communication and connectedness throughout the State. Two RFPs are being administered to provide training for parents in the various issues of teen maturation and how to talk to their children. Positive Choices, Positive Futures is a popular program in Southern Nevada as the Southern Area Health Education Center has been successful in marketing it. An attempt to replicate the program in Northern Nevada is currently being explored.

Materials in the Teen Pregnancy Prevention Resource Center are available to community organizations and other interested parties upon request. The State Health Division maintains the State Teen Pregnancy Prevention website: http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public.

Bureau staff continues to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. Currently an initiative to combine efforts to prevent STDs, HIV and teen pregnancy by addressing common risk factors as well as promoting protective factors is underway. This initiative is a collaboration between the State Department of Education, the State Division of

Mental Health and Developmental Services, the State Division of Child and Family Services, the State Welfare Division, and the State Health Division's Bureau of Family Health Services, Bureau of Community Health, and Bureau of Alcohol and Drug Abuse.

The media campaign with Nevada Broadcasters Association is continuing until September 2004. At that time a new contract will be considered.

The Governor's Youth Advisory Council (GYAC) continues their "Abstinence Works!" presentations on a limited basis. The GYAC is currently evaluating the program in order to decide if they will continue it with revisions, which include a stringent evaluation component, or do something else that targets middle schoolers.

c. Plan for the Coming Year

NPM # 8: FY05. The main activities for Nevada's teen pregnancy prevention initiative will include community involvement through community coalitions, a statewide media campaign, workshops for parents of adolescents, more collaboration between state agencies, and the continuation of the GYAC, which has identified teen pregnancy prevention as its top priority.

Due to Congress reallocating funds to the States based on Census 2000 data, Nevada will continue to receive increased Abstinence Education funds in FY05. The majority of the increased funding will be made available to community coalitions and non-profit organizations through a RFP process. Abstinence funds will be subcontracted to local organizations for use in local interventions. Two subcontracts will be awarded to support programs that educate parents of adolescents, and two will support programs that focus on teen pregnancy prevention for Hispanic/Latino adolescents in Nevada's two most populous counties, Clark (including Las Vegas) and Washoe (including Reno and Sparks).

Materials in the TPP Resource Center are available to community organizations and other interested parties including the public upon request. The SHD maintains the State TPP website: http://health2k.state.nv.us/CAH/teenpregprevention.htm.

Bureau staff will continue to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. Staff will continue collaborating with local programs such as the Clark County Teen Pregnancy Prevention Coalition. The program will also continue to support two teen clinics residing in both Clark and Washoe Counties. In addition SHD staff will collaborate with other state programs to collectively address teen pregnancy prevention. For example, the SHD will continue collaborating with the State Department of Education, the State Department of Mental Health and Developmental Services, the State Welfare Division, and the State Division of Child and Family Services to reduce the incidence of STDs, HIV and teen pregnancy.

The contract with Nevada Broadcasters Association for the teen pregnancy prevention media campaign will be renewed for two more years when it expires September 2004. The dollar amount of the contract will be lessened in order to make more funding available for community programmatic efforts. The Nevada State Health Division will also support the statewide media campaign by printing ads in local newspapers during teen pregnancy prevention month that encourage communication between adolescents and parents.

The GYAC will reevaluate their "Abstinence Works!" presentation for effectiveness and decide if the program should be continued. Based on the direction given by the GYAC, "Abstinence Works!" will be revised or replaced by another like program that has demonstrated effectiveness.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

a. Last Year's Accomplishments

NPM #09: FY 03. The percent of 3rd grade children who have received protective sealants on at least one permanent molar. FY03: 32.5%

For FY 03, the percent was 32.5%. The numerator is the number of 3rd grade children with a sealant. The denominator is the number of 3rd grade children in the state during the year. In FY 2003, the SHD partnered with the Nevada Dental Association to conduct a statewide oral health screening of third graders. Data collected included the percent of third grade children with at least one sealant on a permanent molar. The "Miles for Smiles" mobile dental bus and Saint Mary's Take Care A Van traveled to selected schools throughout the state to estimate sealant prevalence. A convenience sample was selected utilizing geographic diversity and socio-economic status. Socio-economic status was determined by; the percentage of Title I funding and percentage of children qualified for free or reduced meals. This measure is enabling and population based.

Towards the end of FY02, the SHD initiated a partnership for a statewide dental sealant project with Saint Mary's Foundation (Reno), the Nevada Dental Hygienists' Association and the Community College of Southern Nevada Dental Hygiene Program (Las Vegas). The goal was to place dental sealants on the teeth of at least 3,250 second-grade children in 98 schools throughout the state. Schools targeted are rural at-risk schools, rural schools with limited access to dental services, and urban schools with at least a 50% eligibility rate for the free or reduced lunch program. The project was implemented in 2003 but had challenges due to licensing and scope of practice issues.

b. Current Activities

NPM #09: FY 04. The SHD continued to work with the partners on the statewide dental sealant project.

A number of significant challenges were finally resolved in FY 04. There are 17 school districts in Nevada of which Clark County School District (Las Vegas and Henderson) is by far the largest. The Clark County School District has legal requirements that other school district did not have. Determining how best to meet these requirements was extremely challenging. A Memorandum of Agreement between the Clark County School District, and the Board of Regents, University and Community College System of Nevada on behalf of the University of Nevada, Las Vegas School of Dental Medicine and Community College of Southern Nevada Dental Hygiene Program was finally agreed on in December 2003. Signatures were obtained from the General Counsel for the University and Community College System of Nevada, the President of the University of Nevada Las Vegas, the Dean of the UNLV School of Dental Medicine, the Director of Patient Care Services at the UNLV School of Dental Medicine, the President of the Community College of Southern Nevada, the Department Chair of the Dental Science Programs at the Community College of Southern Nevada, the Director of Community Outreach at Saint Mary's Health Network, the Southern Region Coordinator for Seal Nevada and a designated Clark County School District Representative.

On March 25, 2004, the State Board of Dental Examiners finally approved regulations allowing dental hygienists in public health settings to place sealant without a prior diagnosis by a licensed dentist. This change to Nevada Administrative Code (NAC) took almost two years to complete.

Once the change to NAC was approved, a second letter to recruit volunteers to participate in

the program was sent to every Nevada licensed dental hygienist residing in the State. Additional manpower for the sealant program was obtained when the UNLV School of Dental Medicine agreed to have dental students participate.

c. Plan for the Coming Year

NPM #09: FY 05. The SHD will continue to partner with St. Mary's Foundation, the Nevada Dental Hygienists' Association, the UNLV School of Dental Medicine and the Community College of Southern Nevada Dental Hygiene program in the statewide dental sealant project described in FY04.

The SHD will coordinate the scheduling between the schools and the volunteer dentists and dental hygienists. The CDC cooperative agreement funds a half-time position to coordinate the statewide dental sealant program.

The SHD will continue to identify additional resources for the dental sealant program.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

a. Last Year's Accomplishments

NPM # 10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. FY 03: .08

The data for FY 03 for this performance measure is from State vital statistics provided by the CHDR, Bureau of Health Planning and Statistics. This measure is a population-based measure that impacts children from age one through age 14.

The Nevada State Health Division's Injury Prevention Task Force oversees Nevada's injury prevention initiative. Members of the task force include: representatives from the Department of Education, Nevada Department of Transportation, the SHD BLC Emergency Medical Services (EMS), Bureau of Health Planning and Vital Statistics, Clark County Health District, Washoe County District Health Department, SAFE KIDS Clark County, and the Nevada Office of Traffic Safety.

In FY 2003, the Data Linkage Project was completed and two reports were published: An Overview of Injuries in Nevada and An Analysis of the Injury Surveillance Data System in Nevada. These reports assess databases that hold unintentional and intentional injuries in Nevada.

The Injury Prevention Program applied for funding through the Centers for Disease Control and Prevention to implement a program to Nevada's youth to produce and promote a seatbelt prevention campaign. Unfortunately, this funding was not awarded.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety

The Injury Prevention Program performs data surveillance on Motor Vehicle Crashes of children aged 14 years and younger.

b. Current Activities

NPM # 10: FY 04.

The Governor's Youth Advisory Council voted to focus on youth violence issues. They provide age-related input for targeting areas of injury prevention in driver safety, of which they are very concerned. The Council, all of whom are appointed by the Governor, meets 4 times a year and is a forum for presentations and debate on youth safety issues.

The Injury Prevention Program applied for funding through the Centers for Disease Control and Prevention to implement a program to Nevada's youth to produce and promote a seatbelt prevention campaign that will focus on educating newly licensed and teen drivers on the importance of wearing seatbelts to prevent death. Unfortunately, this funding was not awarded.

The Injury Prevention Program participated in the Nevada Occupant Protection Assessment that was conducted by the Nevada Office of Traffic Safety. This assessment has been published and has provided the state with recommendations for highway safety plans relating to seat belts and child safety seats.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

c. Plan for the Coming Year

NPM # 10: FY 05.

The Governor's Youth Advisory Council will be revising membership and will then decide what topics to focus on for the year.

The Injury Prevention Program will be involved in the Highway Safety Summit, to be held in FY 05. This Summit will be organized by the Nevada Department of Transportation, and the goal of the Summit is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

NPM 11: FY 03: 62. Data source: Centers for Disease Control Pediatric Nutrition Surveillance System.

62%, of WIC mothers were breastfeeding upon discharge from the hospital in FY 03. Data is from CDC's nutrition surveillance system, and reports from hospitals in Reno and Las Vegas. The goal for breastfeeding initiation nationwide is 75%. This measure is enabling and population based.

In FY03, WIC clinic staff education continued to be a priority for WIC. There were quarterly staff trainings as well as a quarterly newsletter. The Breastfeeding Coordinator was involved with Task Force activities statewide and provided information and assistance to organizations providing lactation services.

b. Current Activities

NPM 11: FY 04. Semiannual trainings are held and select staff from each local agency statewide receives advanced lactation training, earning the designation of Certified Lactation Counselor. 75% of those counselors were also fluent in Spanish, which addressed the needs of the growing Hispanic population.
The Healthy People 2010 goals also specified breastfeeding duration rates for the infants first year of life (50% at 6 months and 25% at one year). WIC purchased 75 hospital grade electric breast pumps to initiate a pump loan program for participants who would otherwise have had to discontinue breastfeeding due to illness or other extended separations.

The Breastfeeding Coordinator attends conferences and workshops, provides information and assistance to local organizations involved in breastfeeding support and remains active in breastfeeding task forces statewide. In addition, she began work on a self-study module for clinic staff which, at its completion by staff members, will ensure a minimum competency level for breastfeeding knowledge within the clinics.

Finally, she is working with the CHSCN Manager to address getting hospital staff to complete information requested on the newborn screening collection form regarding the status of breastfeeding. Since Nevada requires two screening samples on each baby, completion of the forms will provide a reasonable "snapshot" of the feeding status of babies at discharge, and again in approximately two weeks. Both the CSHCN/ NBS Manager and Breastfeeding Coordinator started to meet with staff at hospitals in Las Vegas to discuss the importance of completing all the information requested on the NBS form.

c. Plan for the Coming Year

NPM 11: FY 05. In FY05 the state WIC Breastfeeding Coordinator will continue to work with the Newborn Screening Program (NBS) (also in the Bureau) to improve and incorporate their breastfeeding data. The Center for Health Data and Research (CHDR) in HP&S can match NBS and WIC data for an unduplicated count. This will represent a more accurate initiation rate statewide as greater than 98% of infants born in Nevada are included in that screening. In addition, it will be possible to determine initiation and short term duration rates by geographic regions and ethnicity statewide.

To increase initiation rates statewide the Breastfeeding Coordinator, in collaboration with Newborn Screening, will offer continuing education credit courses to staff who work in maternal-child healthcare settings such as hospitals and clinics. Providing accurate, updated information will facilitate staff efforts to assist new mothers with breastfeeding and direct them to available referral resources in the community after discharge. One of the deterrents to breastfeeding duration is lack of adequate and knowledgeable support and follow up in the immediate days following hospital discharge. Results from the second screening at two weeks of age will be used to identify the percentage of women who have discontinued breastfeeding in those early days after discharge.

Initiation and short term duration rates gathered from the surveys will be disseminated to lactation consultants and health care personnel involved with newborns statewide. Regions and population groups identified to have lower rates can be targeted for additional breastfeeding promotional and educational activities as well as the possibility for improved support services within the community.

Ongoing activities for FY05 include increasing the number of WIC staff attending advanced lactation training, facilitating changes in the prenatal breastfeeding education provided in the clinics and purchasing more hospital grade electric breast pumps. All staff will continue to receive training at least semiannually and the newsletter and other current educational and promotional items will continue to be made available.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

a. Last Year's Accomplishments

NPM 12. FY03: 94.3The data source for this measure is state birth certificate data from the CHDR and the state-based newborn hearing registry. This measure is population based and direct services.

Effective January 1, 2001, the Nevada Legislature mandated newborn hearing screening for all hospitals that provided birthing services for more than 500 births per year.

Newborn Hearing Screening was implemented in Nevada on January 1, 2002 in all hospitals with at least 500 births a year. Staff met with hospitals mandated to provide hearing screening and mutually developed a data collection matrix and reporting protocol. Hospitals agreed to document and report the number of infants screened quarterly, as well as data on infants who needed referral for further evaluation and treatment. Hospitals were provided with information so referrals would be made to the E.I. multidisciplinary clinics to ensure that all babies would be able to access services. Staff at some hospitals encountered some problems with new equipment and staff training, which were eventually resolved, and the screening of infants proceeded. Facilities submitted data quarterly relative to the number of infants screened and those who were referred for further evaluation.

The Bureau was awarded a grant for the implementation and expansion of a Newborn Hearing Screening program. This grant allows the Bureau to hire a full time position to provide follow back services to assure that all babies detected as needing further evaluation and treatment received those services in a timely manner. A copy of the CY03 report to the Governor is attached.

b. Current Activities

NPM 12. FY04 A Newborn Hearing Screening Coordinator (HPS I) was hired in November of 2003 and left state service in early May of 2004. During that time, the HPS II and HPS I met with hospital staff to discuss the program. Providers agreed to provide data on a monthly basis, and to include not only the information on infants that were referred for further evaluation, but also the information on those infants whose families refused hearing screening prior to discharge. Families who refused testing prior to discharge, as well as those whose infants were referred for further evaluation are sent letters offering services at the E.I. clinics and through the CSHCN Program, should funding be a problem. This practice assures more timely evaluation and treatment initiation of infants.

During this time, the needs assessment process was begun with focus groups in Reno, Elko and Las Vegas being convened. Turnout included a good cross section of the community who are concerned about hearing screening issues. An E.N.T. physician in Reno attended and agreed to assist in the distribution of information to physicians through the Board of Medical Examiners. Members of the hearing impaired groups in Reno and Las Vegas attended, as well as audiologists and concerned CSHCN parents.

Infants who "fail" the initial Newborn Hearing Screening are referred to their PCP and to the E.I. clinics for further evaluation.

Those children determined to have a true hearing problem are then sent to appropriate specialists for assistive devices and/surgical intervention. Families needing financial assistance are referred into the CSHCN program, which can cover the costs associated with surgery and/or hearing aides if needed. The infants continue to be seen and evaluated by E.I. staff to assure that the child meets appropriate developmental milestones. E.I. services transition the children into the school district special education program at 3 years of age, thus avoiding any break in service and assuring that the child achieves its maximum potential. This provided a "seamless" system of assistance to families.

In calendar year 2003, the Newborn Hearing Screening program screened 99.7% of the infants born in Nevada. An annual report was prepared in February 2004 and sent to the office of the Governor as required by NRS.

c. Plan for the Coming Year

NPM 12. FY05. Plans are to re-hire an FTE to continue to work with hospitals to enhance the quality and timeliness of data. Follow-back services will continue to assure that all infants screened received appropriate follow-up treatment if indicated, and will assure referrals to the E.I. services for ongoing developmental assessments and interventions. This position will work with hospital staff and individual providers to enhance data quality and timeliness, as well as develop standardized protocols and procedures for referral. Plans are to link with Medicaid and Nevada Check Up data to improve the capacity to assure effective treatment in a timely fashion.

Legislation in place mandates an annual report to the Governor. However, as the program continues and improves, not only data collection/reporting will improve, but additional analysis will be provided on follow-up, enrollment in E.I. etc. This data will be available for use by the Nevada Advisory Council on CSHCN to utilize in making recommendations for improvements in services to CSHCN. The Council will be created through the support gained through the RCSC grant that will also support a statewide needs assessment.

The bill that established an Office of Disabilities in the DHR Director's Office also established a committee on Deaf and Hard of Hearing. The RCSC team and the Nevada Advisory Council on CSHCN will work with this committee. The RCSC team will link the Office of Disabilities - Deaf and Hard of Hearing committee with the Nevada Advisory Council on CSHCN relative to sharing data from the hearing needs assessment, transition issues and recommendations made as a result of the RCSC needs assessment.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

NPM 13: FY 03: 19.1% The most recent reliable estimate of the percent of Nevada children without health insurance was 19.1%. The number of children birth to eighteen without health insurance (112,259 in 2002) is based on an "Uninsured Persons in Nevada" study conducted by Decision Analytics in 2003 for Great Basin Primary Care Association through funding by the Bureau's PCDC. The number of children birth to eighteen (587,695) was obtained from a July 1, 2002 population estimate by the Bureau of Health Planning and Statistics. Efforts to improve this measure are related to Infrastructure Services in terms of the Performance Measurement System.

It is generally agreed that the most important reason for a decrease in the percent of children without health insurance was the significant increase in enrollment in Nevada Check Up.

Nevada Check Up is the State Childrens Health Insurance Program for children 0-18. Over half of uninsured Nevadans are working families and less than one-third of uninsured children in the state live below the federal poverty level. Nevada Check Up covers up to 200% of the federal poverty level. Nevada Check Up dramatically increased enrollment during the past two years to approximately 25,000 children. The Bureau worked very closely with Nevada Check Up; a report on its progress is a standing agenda item for the Maternal and Child Health Advisory Board.

Major activities related to the decrease included improvement of the primary care safety net to promote access to care and public and private programs targeted to children. BFHS carried out a range of free public health programs and services which contributed to improving this performance measure by compensating for the lack of health insurance suffered by such a large number of children in the state. PCDC represents the Bureau's main effort related to improvement of the primary care safety net to promote access to primary care. The primary care safety net is another means for mitigating the limitations to care related to lack of medical insurance for children. Other Bureau programs that promoted access to care included Baby Your Baby, which refers callers to Medicaid and Nevada Check up as well as other programs that might serve and refer them such as WIC and CSHCN.

b. Current Activities

NPM 13: FY04. Because of the gradual increase in enrollment in Nevada Check Up, it is generally agreed that the percentage of uninsured children stabilized or decreased slightly. This was despite an overall decline in the economy. Nevertheless, Nevada's percent of total uninsured persons remains consistently higher than the national average. National research and Nevada studies clearly demonstrate that uninsured children do not get the health care they need. This is particularly true for rural residents who are more to be uninsured and less likely to be offered coverage through employers. Uninsured children have fewer physician visits per year, are less likely to receive adequate preventive services and immunizations, and are less likely to be seen by physicians when they are ill.

In FY 04 as in the preceding year, the Bureau carried out a range of free public health programs and services that offset the obstacles hindering access to care caused by lack of medical insurance. Uninsured children would be very unlikely to receive these kinds of services and benefits otherwise. The MCH Perinatal Program was designed to reduce infant mortality and morbidity by establishing statewide systems of perinatal care to ensure that pregnant women have access to prenatal care regardless of ability to pay. Although no longer paying for prenatal care, the MCH Campaign continues to work to establish and maintain systems of care for underserved pregnant women. The MCH Campaign Information and Referral Line (IRL) refers to pediatric as well as prenatal care. The Bureau's Child and Adolescent Health program promotes healthy behaviors among Nevada's youth through organized community efforts, public awareness campaigns, educational programs, and prevention activities. The CSHCN program provides a range of services that are coordinated, family-centered, community-based, and culturally competent. The Oral Health program provides preventive and health education services to children throughout the state. The purpose of the Women, Infants, and Children (WIC) program is to improve the nutritional health status of low-income women. infants, and children through nutrition education, vouchers for supplemental foods, and referral to community resources including medical and dental care. A new program, Real Choice Systems Change, seeks to enhance linkages and improve coordination of services for CSHCN. PCDC continued to represent the Bureau's main effort related to improvement of the primary care safety net to promote access to primary care. The primary care safety net is another means for

mitigating the limitations to care related to lack of medical insurance for children.

c. Plan for the Coming Year

NPM 13: FY 05. In the future, the Bureau will continue to carry out its ongoing activities outlined above, all of which serve to ameliorate the impact of lack of health insurance on Nevada's children. The Bureau will also continue to work closely with Nevada Check Up, which is expected to continue to increase enrollment. The Bureau, mainly through PCDC, will continue its work related to improvement of the primary care safety net to promote access to care. These efforts are targeted to the medically underserved, most of whom are uninsured or underinsured. The medically underserved are spread throughout Nevada's vast rural areas and in pockets of poverty in Nevada's two urban centers.

PCDC will also continue to support community development activities related to improvement of primary care resources available to medically underserved populations which, in turn, serves to offset the impact of lack of health insurance among children. Key partners for PCDC include GBPCA, University of Nevada School of Medicine, Nevada Health Centers, and Nevada Rural Hospital Partners, and the Office of Rural Health. These activities represented the leading efforts related to this measure and will continue to be the leading efforts next year.

The MCH Campaign IRL will continue to be a resource for referral to pediatric care including Medicaid and Nevada Check Up coverage.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

NPM 14: FY03: 90%

The State Medicaid Program was unable to provide data regarding the number of potentially eligible children. However, they were able to tell us that in Calendar year 2003, there was a total of 84,152 children ages 0-18 on the program. Of these, 4,5997 children ages 0-18 were on the Medical Assistance to the Blind and Disabled (MAABD) program. This measure is infrastructure building.

In Nevada, there is no "presumptive eligibility" available to families. Women and children are either "eligible" or "not eligible" for coverage under the Medicaid program. Persons who are "Pending" determination for Medicaid eligibility rarely are able to access services such as outpatient visits or pharmacy. The Medicaid eligibility is determined on a "month to month" basis, so providers are reluctant to chance providing services for which there may be no reimbursement available.

The SHD, including the Bureau, was in close contact with staff of Medicaid and Nevada Check Up throughout the year. The MCHAB continued to watch very closely Nevada's changing health care system and the implementation of Medicaid Managed Care and Nevada Check Up. The Chief of Medicaid Managed Care and Nevada Check Up of DHCFP provided regular updates to the MCHAB and ensured close collaboration of his staff with Bureau staff. The Bureau continued to look for ways to perform outreach for Medicaid and Nevada Check Up. Referrals to Medicaid and Nevada Check Up were made through the CSHCN Program, BYB campaign, and WIC. Bureau staff is able to check Medicaid and Nevada Check Up eligibility electronically, facilitating referrals and preventing duplication.

b. Current Activities

NPM 14. FY04. Children in need of medical services, including those on Medicaid, access care through a variety of channels. Hospitals and community clinics often provide services on a "sliding scale" and then assist families to apply for Medicaid programs after the fact. At the present time, there is no way of tracking these potentially eligible individuals.

The implementation of Medicaid managed care enrollment is closely monitored by the Bureau including the PCDC. The MCH campaign, which replaced BYB, is also a source of information. The multi media component encourages families to seek a Medical Home for their children and provide public health education on the value of primary and preventive care. It also refers families to Medicaid for coverage of pediatric services.

The SHD, including the Bureau, is in close contact with staff of Medicaid. The MCHAB continues to watch very closely Nevada's changing health care system and implementation of Medicaid Managed care, particularly for dental services. The Chief of Medicaid Managed Care and Nevada Check Up of the DHCP & F continues to provide regular updates to the MCHAB and with the MCH chief ensures the close collaboration of his staff with Bureau staff. Referrals to Medicaid are made through the CSHCN Program, MCH campaign and WIC. Bureau staff is able to check Medicaid eligibility electronically, facilitating referrals and preventing duplication.

The SHD works with local hospitals and community funded clinics to assure all children have access to necessary medical services.

The is no "presumptive eligibility" program in the Nevada Medicaid program. Thus, Medicaid is unable to provide reliable data on this issue. At the present time, there is no way of tracking these potentially eligible individuals. As in prior years this is an estimate; with the new data linkages it should be possible to get better data for this measure in the future.

c. Plan for the Coming Year

NPM 14: FY05. Access to services by Medicaid and Nevada Check Up for eligible children will continue to be closely monitored by the Bureau, including PCDC, in FY05. The MCH Campaign will continue to be a source of information and referral. A campaign to encourage families to seek a Medical Home for their children will continue. The IRL will continue to refer callers with children, or expecting children, to Medicaid for coverage of prenatal and pediatric services.

The SHD, including the Bureau, will remain in close contact with staff of Medicaid. The MCHAB will continue to have Medicaid and Nevada Check Up access to services for eligible children as a standing agenda item. Staff of DHCP & F and the Bureau will continue to work together to address unmet need.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

NPM#15. Percent of very low birth weight infants among all live births. FY03: 1.3%

FY 03: This measure is an infrastructure-building performance measure that is impacted by all births within the state. Data for this performance measure comes from State Vital Statistics, Center for Health Data and Research (CHDR). This performance measure is affected through public health education measures such as the Baby Your Baby (BYB) campaign, perinatal substance abuse prevention (PSAP) initiatives, the Womens, Infants and Childrens (WIC) program, the Maternal/Child Health (MCH) Prenatal Program, Medicaid MOMS program and provider education.

Access to prenatal care has been demonstrated to be a priority component of achieving healthy birth outcomes. The Bureau has worked with agencies to promote access to prenatal care including those whose services target high risk Hispanic and African American Women. The Economic Opportunity Board (EOB) served areas of Las Vegas and North Las Vegas with high minority populations. The MCH contracted with EOB to provide support for appropriate obstetric services for their clients. It has WIC clinics on site. MCH also provided funding for Community Health Nursing (CHN) services in Nevada's 15 rural counties. The CHN's provide pregnancy testing and family planning services as well as referrals to BYB and MCH Prenatal in their clinics.

The Bureau continually worked to partner with Medicaid in promoting the health and well being of Medicaid pregnant women and then their infants. All women who call the BYB Information and Referral Line are screened for insurance needs. If they do not have insurance, they are referred to Medicaid or Nevada Check Up. They bureau also partners with the Medicaid MOMS program to provide clients with information on prenatal care, self-care during pregnancy and after the pregnancy, care of the infant.

The BYB mass media campaign designed to encourage women to enter early prenatal care continued throughout the state.

Prenatal providers were kept abreast on perinatal issues, including folic acid consumption, nutritional information, HIV screening and treatment, immunizations during pregnancy and infections during pregnancy.

The Bureau's MCH Prenatal Program continued to be a safety net for pregnant women who were not eligible for Medicaid or Nevada Check Up.

b. Current Activities

NPM # 15: FY 04:

Most WIC clinics throughout the state were transferred from state-run agencies to community-based organizations. Their clients are taught about healthy nutrition in pregnancy, in order to increase the likelihood of a healthy pregnancy outcome for both mother and baby.

The Bureau has withdrawn from the "Baby Your Baby" (BYB) campaign and has begun a state-wide "Maternal and Child Health" Campaign, which emphasizes the need for women to enter prenatal care in their first trimester. One of the top goals of the campaign is to reduce the low birth weight rate. An information and referral line is available 24 hours a day where Nevadans may obtain information about services available for pregnant women in their community.

The Bureau continues to work with Medicaid to promote the health and well-being of Medicaid pregnant women and their infants.

The Perinatal Substance Abuse Prevention (PSAP) program has continued to collaborate with both public and private agencies on eliminating tobacco intake during pregnancy and postpartum. A new law (SB 307) requires all restaurants that serve liquor to prominently post a warning about drinking during pregnancy. The PSAP initiative has been working to ensure that knowledge of this law is known throughout the state. The PSAP program has also been awarded a grant by the Children's Trust Fund (CTF) to conduct a Fetal Alcohol Spectrum Disorders (FASD) public-education campaign in Nevada.

The MCH Prenatal Program continued to be a safety net for pregnant women who are not eligible for Medicaid or Nevada Check Up until May 15, 2004.

c. Plan for the Coming Year

NPM # 15: FY 05:

Future plans to impact the low birth weight rate includes continuing the Maternal and Child Health Campaign and collaboration with Medicaid. The Bureau has sent out a "request for proposal" (RFP) to all agencies that may want to care for low-income pregnant women. The best proposals will be awarded in the near future. The scope of work on the proposals is to specifically include social service referrals as needed and nutritional counseling for all clients. In addition, in order to educate women about this and the need for early prenatal care, the Bureau is in the process of contracting with the Nevada Broadcaster's Association (NBA) to produce radio and television spots about this subject. The spots will be produced in both English and Spanish and will be broadcast state-wide.

The MCH Prenatal Program has been discontinued and the money from this program will go into the new Maternal and Child Health Campaign. Most of this money will go toward the RFP contract awardees for community-based services.

The Perinatal Substance Abuse Prevention (PSAP) campaign will continue working with private and public agencies to educate the public about the dangers of tobacco, alcohol and drug use during pregnancy.

Prenatal providers will continue to be kept abreast on perinatal issues, including folic acid consumption, nutritional information, HIV screening and treatment, immunizations during pregnancy and infections during pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

NPM #16: The rate (per 100,000) of suicide deaths among youths aged 15 - 19.
FY 03: 5.8.
Data reported for this performance measure comes from the CHDR, death certificates. This measure is an infrastructure building measure and affects children from age fifteen through nineteen.

The 2003 Youth Risk Behavior Survey (YRBS) reported 18% of Nevada's high school students have seriously considered suicide during the past 12 months. Fifteen percent planned how they would commit suicide and 9% actually attempted suicide, a decrease of three percentage points from the 2001 YRBS.

The 2002-2004 Governor's Youth Advisory Council again selected suicide prevention as one of their top priorities. They established a Subcommittee that met twice to explore prevention activities. They recommended that suicide prevention be added to school district curriculums, but no further activity was undertaken.

The Injury Prevention Program applied for and received funding through the Centers for Disease Control and Prevention for Youth Suicide Prevention. The Youth Suicide Prevention funding was used to implement a program to Nevada's 15-19 year-olds, providing youth suicide prevention presentations, statewide coalition building among county agencies and members, training efforts, and public awareness campaigns.

The Injury Prevention Program, in collaboration with the Nevada State Health Division's Center for Health Data and Research, completed Data Surveillance of Suicides in Nevada in 2002. The Bureau participated and collaborated in the Suicide Prevention Statewide Study conducted by the Nevada State Legislature.

The PCDC continued to keep mental health HPSA's, MUA's, and MUP's up to date.

b. Current Activities

NPM # 16: FY 04. The attempted and completed suicide rate in Nevada remains one of the worst in the nation.

The Bureau is continuing to participate and collaborate in the Suicide Prevention Statewide Study of the Legislature that is being conducted.

Collaboration is also continuing with the Crisis Call Center of Northern Nevada. The Crisis Call Center has received a sub grant from the Nevada State Health Division to provide youth suicide prevention presentations, statewide coalition building among county agencies and members, training efforts, and public awareness campaigns.

The Governor's Youth Advisory Council has again selected suicide prevention as one of their top priorities. They are currently recruiting new members and will soon start to focus on their priorities.

PCDC is continuing to work with GBPCA to promote sites where mental health services for adolescents can be obtained.

c. Plan for the Coming Year

NPM # 16: FY 05: The Data Surveillance of Suicides in Nevada will continue through 2005.

The Injury Prevention Program has applied for a non-competing supplemental grant through the Centers for Disease Control and Prevention (CDC) for Violence Surveillance Integration. This funding will require Nevada to integrate Violence Surveillance into the current Core State Injury Surveillance System. Violence Surveillance includes suicide mortality data and hospitalization for self-inflicted injuries data for the state. This data will be reported to the CDC.

The Governor's Youth Advisory Council will continue to focus on adolescent suicide prevention and will advise the health division and the Governor on the issue.

PCDC will continue to work with GBPCA to promote sites where mental health services for adolescents can be obtained.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

NPM #17. Percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates. FY03: 92.6%

The data for this measure has come from State vital statistics, CHDR.
This measure is an infrastructure building measure that impacts all low birthweight infants born in Nevada. Infants should be delivered at facilities that have appropriate care to match their needs.

Since 1990, Nevada has seen an increase in the number of Level III hospital facilities in both Clark and Washoe Counties, where 85% of Nevada's population reside. MCH promoted the BYB campaign throughout the state to encourage all pregnant women to enter prenatal care in the first trimester, thus receiving assessments for adverse birth outcomes and appropriate intervention.

MCH continued to work with the Primary Care Development Center (PCDC) to promote access to obstetrical services in rural communities. All perinatologists in the state were and are providers for the MCH prenatal program. This program has been a safety net for pregnant women who do not qualify for Medicaid or Nevada Check Up, nor do most have insurance. This program paid for prenatal care for women, encouraging them to seek early and continuous and appropriate prenatal care. Women who are at high-risk of delivering a very low birth weight infant could seek care by a physician who delivers at a facility for high-risk deliveries.

The Statewide BYB Campaign encourages all pregnant women to enter prenatal care in the first trimester, thus receiving assessments for adverse birth outcomes and appropriate intervention.

b. Current Activities

NPM # 17: FY 04:
Two new hospitals were added in the Southern Nevada area, which may bring about another Level III facility.

The Baby Your Baby campaign, which ended in December 31, 2003, continued to have television spots encouraging women to enter early prenatal care. The MCH Campaign, which took its place, continues with a media campaign and referrals to prenatal (and pediatric) care.

The statutes covering Level I, Level II and Level III newborn and intensive care nurseries were reviewed in the past year by the Bureau and BLC through a Subcommittee of the MCHAB, with recommended changes taken to the MCHAB and then to the State Board of Health June 2004 for adoption. There they were adopted after no comments were received from those attending. Representatives of the MCHAB Subcommittee on the regulations were there, and reported it took about 20 seconds to pass them. These regulations update the regulations to current standards per the AAP. These regulations (now NAC) should make it easier for the various nurseries to work within their scope and will foster a better working relationship between nurseries and neonatal intensive care units in the future.

c. Plan for the Coming Year

NPM # 17: FY 05:

The Maternal and Child Health Campaign will air announcements on television and radio about the importance of entering early and continuous prenatal care. In addition, the contracted community based prenatal care providers will be required to refer high-risk pregnant women to

appropriate services, both medical and social. This will include referring women to physicians who deliver high-risk mothers at a facility with a Level III nursery.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

NPM #18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. FY03: 75.6 %

Data for this infrastructure building performance measure has come from State Vital Statistics and affects all newborns within the state. It is desired that all infants in Nevada be born to pregnant women receiving prenatal care beginning in the first trimester and continuing throughout the pregnancy.

Factors affecting Nevada's rate for early entry into prenatal care include its ongoing population growth and the growth of the Hispanic population in particular which historically does not enter into prenatal care until much later in the pregnancy.

Another factor that has affected the decline in the number of women who enter prenatal care in the first trimester is the number of obstetrical physicians available. Due to a medical malpractice crisis, many physicians either stopped providing obstetrical services, won't see women before 12 weeks gestation, or moved out of state. MCH has collaborated with all of the hospitals in Southern Nevada, where the crisis is, to increase the number of providers practicing obstetrics. Nevada has also worked to encourage more obstetrical providers to practice in Nevada. To help attain this goal, the state legislature passed new legislation through a "special session" in 2002, which limits malpractice awards. In addition, the state has developed its own malpractice insurance pool which offers reduced rates to obstetrical providers. This has alleviated the physician shortage crisis to a degree, although most physicians' malpractice coverage through private carriers continues to be extremely high.

b. Current Activities

NPM # 18: FY 04:

The MCH Prenatal was a program for pregnant women who meet eligibility criteria as listed in NAC. It was established at 250% of the Federal Poverty Level, with legal residency in the Nation and Nevada residency required. This program is designed to encourage women to access early and continuous prenatal care by providing financial assistance for the prenatal care. Women may not qualify for the assistance if they are more than 24 weeks gestation. This policy was put into affect so women would not wait for their care, but instead be encouraged to seek early care. It was discontinued May 15, 2004. Women already eligible or with an application in that is determined eligible for the program are being covered to delivery.

The Bureau contracts with the Economic Opportunity Board of Clark County to provide obstetrical services to low income women, thus helping women who cannot afford prenatal care, and may not qualify for Medicaid, to obtain early and continuous prenatal care. The Washoe County District Health Department also receives Bureau assistance to provide care to high-risk women in Washoe County.

"Requests for Proposals" (RFP's) were sent out in May 2004 for prenatal care services to low-income pregnant women. It was anticipated that several providers may offer innovative ways to

provide prenatal care, and the Bureau could choose from the best proposals. These RFPs were opened in June 2004. University Medical Center In Las Vegas was selected for the first contract.

c. Plan for the Coming Year

NPM #18: FY 05:

The MCH Prenatal Program has noted above has been discontinued. The Bureau will shift funding for prenatal care to community-based providers who will care for low-income, high-risk pregnant women. Future plans include sending out "Requests for Proposals" (RFP's) with the additional funding (which includes additional Title V block grant funds) as was done in FY 04 in the next year for prenatal care services to low-income pregnant women. It is anticipated that several providers may offer innovative ways to provide prenatal care, and the Bureau can choose from the best proposals.

The Bureau will also be conducting an educational campaign to make women aware of the need for early and continuous prenatal care. This will be a state-wide campaign on television and radio and will be aired in English and Spanish. To complement the educational campaign, the Bureau maintains a toll-free, state-wide health line where women and families can access information regarding a variety of information, including where to obtain prenatal care and social/mental health services.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Newborn Screening program assures access to follow-up services (coverage of consults, etc.)	☐	☑	☐	☐
2. Newborn Screening cases are automatically referred to CSHCN Program (for coverage of consults etc.)	☐	☑	☐	☐
3. CSHCN program provides for purchase of special formula and food products for eligible individuals.	☐	☑	☐	☐
4. CSHCN program provides appropriate referral to a variety of resources and maintains a "NBS registry"	☐	☑	☐	☑
5. Registry triggers annual family update to determine family's status,assure child receiving services	☐	☐	☐	☑
6. The Bureau will continue to manage the NBS statewide program.	☐	☐	☑	☐
7. The Bureau will continue to support specialty metabolic clinic services				

	☑	☑	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. CSHCN will continue to work with and include Family Ties representative in policy development.	☐	☑	☐	☐
2. CSHCN will work with Family Ties representatives to develop training to empower parents and CSHCN.	☐	☑	☐	☐
3. CSHCN will work with Family Ties and E.I.to develop increased Family Ties involvement with E.I.	☐	☑	☐	☐
4. The CSHCN program will continue to provide program applicants information for Family Ties	☐	☑	☐	☐
5. CSHCN will work with RCSC contractor to complete a needs assessment of services & support available	☐	☐	☐	☑
6. The CSHCN program staff will coordinate the establishment of a "Nevada Advisory Council on CSHCN".	☐	☑	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. CSHCN will cover services by the PCP on a quarterly basis while the child?s condition is stable.	☐	☑	☐	☐
2. CSHCN requires Sub-specialist consultation once a year.	☐	☑	☐	☐
3. The CSHCN program encourages families to establish a PCP as a medical home.	☐	☑	☐	☐
4. CSHCN will develop a mechanism to act as a referral for a medical home for all CSHCN in state.	☐	☑	☐	☐
5. CSHCN will work with Medicaid to increase the E.P.S.D.T. rate for CSHCN in Nevada.	☐	☑	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐

10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. CSHCN will assist families in applying for Medicaid & Nevada Check Up with information & referral.	☐	☑	☐	☐
2. CSHCN will advise referred families to request an E.P.S.D.T. examination for their child.	☐	☑	☐	☐
3. CSHCN will provide advocacy for families during the Medicaid & Check Up application process	☐	☑	☐	☐
4. CSHCN will provide information & advocacy with private insurance companies to access needed services	☐	☑	☐	☐
5. CSHCN will work with Medicaid to identify CSHCN in Medicaid HMOs to assure appropriate services.	☐	☑	☐	☐
6. The RCSC Project Team will continue with its partnerships with the Nevada Broadcaster's Association, and Covering Kids to increase awareness of available public programs and services available to all children, including CSHCN	☐	☐	☑	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. CSHCN will update referral information on eligibility criteria for Medicaid, food stamps,etc.	☐	☑	☐	☐
2. CSHCN will maintain current referral lists of local providers for pharmacy, transportation etc.	☐	☑	☐	☐
3. CSHCN will maintain current referral lists of local volunteer organizations for uncovered services	☐	☑	☐	☐
4. CSHCN will provide information, advocacy to families & providers to access community-based services.	☐	☑	☐	☐
5. CSHCN will provide training to parent groups to assist in accessing programs and services.	☐	☑	☐	☐
6. CSHCN and the RCSC contractor will complete a comprehensive CSHCN needs assessment.	☐	☐	☐	☑
7. CSHCN will work with contractor & Nevada Advisory Council on CSHCN to develop action plan	☐	☐	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐

10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. CSHCN will counsel parents regarding having PCP assist with referral to adult health care providers.	☑	☑	☐	☐
2. CSHCN will provide information for families regarding SSI eligibility, Medicaid eligibility, etc.	☐	☑	☐	☐
3. CSHCN will provide family information regarding IEP for appropriate vocational training of CSHCN.	☑	☑	☐	☐
4. CSHCN will encourage families to be involved with the educational plan for their child.	☑	☑	☐	☐
5. PCPs & families will be given information on adult care providers to work with specific conditions.	☑	☑	☐	☐
6. PCPs and families will be given information where in community ancillary services may be available.	☑	☑	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Continue developing WIC clinic linkage with State Immunization registry and WIC marketing campaign with Immunizations.	☐	☑	☐	☐
2. Continue referral of WIC participants to immunizations for those who need them.	☐	☑	☐	☐
3. Continue funding Community Health Nursing Clinics services which include immunizations.	☐	☑	☐	☐
4. Contract with the WCDHD for well-child services that include immunizations.	☐	☑	☐	☐
5. Include a multi-media campaign for immunization month in the MCH Campaign.	☐	☐	☑	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Support community coalitions and organizations (including ones emphasizing minority populations) by making federal Abstinence-Only(A-O)Education funds available for contracts for A-O programs and developing partnerships with the GYAC.	☐	☑	☐	☐
2. GYAC's continued commitment to teen pregnancy prevention as their top priority.	☐	☑	☐	☐
3. Development and implementation of teen pregnancy prevention programs specifically targeting Hispanic/Latino populations in Washoe and Clark Counties	☐	☑	☐	☐
4. Continuation of statewide media campaign with NBA promoting sexual abstinence until marriage	☐	☐	☑	☐
5. Continuation of workshop for parents of adolescents on importance of healthy sexuality	☐	☑	☐	☐
6. Continue workshop for parents of youth on sexuality with emphasis on Hispanic families in Clark Co.	☐	☑	☐	☐
7. Continue of statewide "Abstinence Works!" presentations or its successor (also offered in Spanish)	☐	☑	☐	☐
8. Continue maintenance of TPP webpage and resource center.	☐	☐	☑	☐
9. Continue supporting teen health clinics in Washoe and Clark Counties.	☑	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Continue to collaborate with Saint Mary's, Community College of Southern Nevada, UNLV School of Dental Medicine and the Nevada Dental Hygienists? Association on the sealant program.	☐	☑	☐	☐
2. Continue to identify target schools	☐	☑	☐	☐
3. Continue to schedule schools, volunteer dentists, dental students, dental hygienists and dental hygiene students.	☐	☑	☐	☐
4. Continue to collect, analyze and report data on sealants.	☐	☐	☐	☑
5. Promote sealant placement by Medicaid and Nevada Check Up providers and by the private practice community.	☐	☐	☑	☐
6. Continue to identify additional resources for the sealant program.	☐	☑	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Injury Prevention performs data surveillance on MVC of children aged 14 years and younger.	☐	☐	☐	☑
2. Injury Prevention Program is performing a cross match which identifies MVC deaths.	☐	☐	☐	☑
3. Injury Prevention Program will be collaborating with Nevada's DOT in a "Highway Safety Summit".	☐	☐	☑	☐
4. Injury Prevention will continue to collaborate with NDOT, NDMV, NDPS, and Office of Traffic Safety.	☐	☐	☑	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. WIC will partner with NBS Program and the CHDR for more accurate breastfeeding data.	☐	☐	☐	☑
2. Disseminate statistics to lactation consultants etc.to target activities in identified areas.	☐	☐	☐	☑
3. WIC will continue to promote breastfeeding and provide breastfeeding education in clinics statewide	☐	☑	☐	☐
4. WIC will network with other lactation consultants and healthcare providers statewide to promote BF.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. CSHCN staff will continue to work with hospitals to continue to receive NBHS data monthly.	☐	☐	☑	☑
2. CSHCN staff will work with hospitals to refer "failed" cases to their medical home and E.I. services	☐	☑	☐	☐
3. CSHCN staff will compile data for annual report to Governor				

	☐	☐	☐	☑
4. CSHCN will develop and implement a provider training module on NBHS to be used with PCPs.	☐	☑	☑	☐
5. CSHCN will enter cases into a "registry" that will provide annual updates and assure continuity of care.	☐	☑	☐	☐
6. The registry will also provide a database of how many children have a hearing impairment.	☐	☐	☐	☑
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Support expansion of the Nevada Check Up program to increase enrollment.	☐	☑	☐	☐
2. Designate primary care, dental and mental health HPSAs, MUAs and MUPs and develope additional sites.	☐	☑	☐	☐
3. Promote referrals from public and private programs targeted to children,i.e. E.I., WIC, CSHCN, MCH Campaign, Real Choice Systems Change.	☐	☑	☐	☐
4. Update Nevada Uninsured Study every two years to assess need.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. SHD staff will work with DHCFP regarding getting service related data.	☐	☐	☐	☑
2. The Bureau will work with public & private providers to assure children access medical services.	☐	☑	☐	☐
3. Referrals to Medicaid will continue to be made by MCH Campaign - IRL, WIC, E.I. and CSHCN.	☐	☑	☐	☐
4. The Bureau will work with DHCFP regarding getting data related to how many children have a medical home.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐

8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Continue to perform outreach and enroll qualified pregnant women into WIC.	☐	☑	☐	☐
2. Continue to provide obstetrical coverage for women through community based programs.	☐	☑	☐	☐
3. Encourage early entry into prenatal care for all women in NV through the Maternal and Child Health campaign.	☐	☐	☑	☐
4. Collaborate with Medicaid to educate pregnant women about pregnancy, nutrition, tobacco & drug abuse.	☐	☑	☐	☐
5. Collaborate with MCHAB to educate public & providers on risks of having a low birth weight baby	☐	☑	☐	☐
6. Continue to work with EOB, GBPCA members and other providers to develop sites for prenatal care.	☐	☑	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. The GYAC selected suicide prevention as one of their top priorities for 2002-2004. A subject specific subcommittee has been selected to develop activities and recommendations and will meet the summer of 2004.	☐	☑	☐	☐
2. Injury Prevention will continue to track suicide in the Injury data base.	☐	☐	☐	☑
3. Injury Prevention continues to participate in the statewide suicide prevention study of NV Legislature which will report in the FY 05 session.	☐	☐	☑	☐
4. Injury Prevention Program will continue to collaborate with Crisis Call Center of Northern Nevada.	☐	☑	☐	☐
5. Injury Prevention will continue to apply for suicide prevention funding targeting youth	☐	☑	☐	☐
6. The PCDC will continue to designate Mental Health HPSAs, MUPs and MUAs	☐	☑	☐	☐
7. An anticipated supplemental CDC grant for Violence Surveillance will require Nevada to integrate Violence Surveillance into the current Core State Injury Surveillance System and report it to CDC.	☐	☐	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐

10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Perform outreach and enroll qualified pregnant women into WIC, where they will receive referrals to needed services.	☐	☑	☐	☐
2. Review and revise NAC re NICUs to ensure up-to-date requirements.	☐	☑	☐	☐
3. Provide obstetrical coverage for women through community based providers.	☐	☑	☐	☐
4. Promote early entry into prenatal care for all women in NV through the Maternal and Child Health Campaign.	☐	☐	☑	☐
5. Collaborate with MCHAB to educate public and providers about risks of having low birth weight baby.	☐	☑	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Sponsor news reports & public service announcements on TV about need for early prenatal care.	☐	☐	☑	☐
2. Distribute brochures and other printed materials at clinics, health fairs on early prenatal care.	☐	☐	☑	☐
3. Collaborate with providers to offer prenatal care to pregnant women regardless of ability to pay.	☐	☑	☐	☐
4. Provide prenatal care to low-income pregnant women through contracted agencies.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *SPM 11. The percent of women of child-bearing age who need assistance and receive it for domestic violence from an agency or shelter should be increased.*

a. Last Year's Accomplishments

SPM # 11. The percent of women of childbearing age who need assistance and receive it for domestic violence from an agency or shelter should be increased. FY 03: 7.4%

This data comes from the Nevada Network Against Domestic Violence for the numerator, and the denominator is from the State Vital Statistics, CHDR, using census data and data from the state demographer.

This population based state performance measure is used to measure how many women have been screened and assisted for domestic violence. Increased assistance from the community and health care providers to women subject to intimate partner violence is needed in order to help all the women who are victims of this violence.

As a result of a needs assessment, the Bureau, in collaboration with the Nevada Health Care Standards Team, established domestic violence health screening protocols and conducted training to health care providers.

Collaboration with community-based agencies has occurred including individual shelters, and callers to the toll-free, state-wide "Baby Your Baby" Information and Referral Line were referred to the appropriate agency in their community for help.

The Bureau has also been represented on the Nevada Attorney General's Domestic Violence Prevention Council, which oversees violence against women activities state-wide, including working with the police and court system. Through the Council, grants are given to various community organizations to help victims of domestic violence, conduct media campaigns about domestic violence prevention, and conduct activities within the school system to make children aware of domestic violence issues.

b. Current Activities

SPM #11: FY 04:

Current activities involve continued domestic violence screening classes for health care providers. In addition, an "expert witness" seminar to instruct attorneys about prosecuting domestic violence cases, and when they should utilize domestic violence expert witnesses has been held twice this fiscal year.

The Bureau, in collaboration with Vital Statistics, reviewed maternal deaths up to one year postpartum from all causes except accidents for the past twelve years. Suicide was the number one cause of death and homicide the second highest cause of death. Fifty-seven percent of the homicides were due to domestic violence. This information has been presented at the Rural Health Conference and the 1st Lady's Women's Health Conference in Nevada in this year.

The Bureau's Maternal and Child Health Line, which can be accessed 24-hours a day, has a bilingual operator (English and Spanish) available and can refer callers to the line to appropriate domestic violence services in their community.

The Bureau continues to be represented on the Nevada Attorney General's Domestic Violence Prevention Council.

c. Plan for the Coming Year

SPM # 11: FY 05:

The domestic violence screening protocols that have been developed by the Health Care Standards Team will be disseminated to the colleges and universities within the state to be placed in their health curriculums. Future plans are to meet with individual health care instructors to discuss the protocols with them, and possibly conduct guest lectures to their students.

In-service education to medical personnel will also take place in the coming year. Screening and Assessment will be stressed, and health care providers will be given information on where to refer clients who need further assistance or shelter.

The Bureau will continue to have the state-wide, toll-free Maternal and Child Health Line available for callers needing referral to a social service agency in their area. In addition, staff will attend health fairs throughout the state to educate women and families about the availability of the line, and the services offered.

Increasing awareness of the role domestic violence plays in maternal deaths will be a priority in the coming year.

State Performance Measure 2: *SPM 12. The percent of women, children, and youth (ages birth to 21) who have access to preventive oral services and dental care, regardless of ability to pay, should be increased.*

a. Last Year's Accomplishments

SPM #12: FY 03. Access to preventive oral services and dental care, regardless of ability to pay, should be increased for children, youth and women of childbearing age. FY03: 1.23

For FY03: the rate is 1.23 per 1,000. The numerator is the number of dentists in the state (1,290.) The denominator is the number of children, youth and women of childbearing age in the state (1,047,193.) The numerator, number of dentists in the state, is from the State Board of Dental Examiners. The denominator is the sum of children, youth and women of childbearing age in the state (CHDR and State demographer). This measure relates directly to priority 10 relating to access to dental care as part of priority care, priority 9, reducing the incidence of early childhood caries, and priority 5, related to dental care for pregnant women.

In FY 03, the SHD continued to receive funding from the CDC to maintain and expand the State Office of Oral Health within the Bureau. The CDC Oral Health cooperative agreement funds activities that support the improvement of the oral health provider network to Nevada's most needy.

SB 133, which established licensure by credential for dentists in Nevada was fully implemented in FY 03. In 2003 there were 161 dentists that obtained licenses to practice dentistry in the State through licensure by credential. Of the 161 dentists, 86 (53%) had provided the Nevada State Board of Dental Examiners with a Nevada address. The remainder have out of state addresses. Of the 86 dentists with temporary, limited, restricted or geographically restricted Nevada licenses and with a Nevada address, 35 (40%) have worked or are working in a setting other than private practice. (According to the American Dental Association, 90% of all dentists are in private practice.) Health Access Washoe County (HAWC) Community Health Center is the 4th largest fee-for-service Medicaid provider in Nevada. Three of the 4 dentists HAWC employs are licensed by credential. Saint Mary's employs one dentist. She is licensed by credential. In 2003, one of the 51 dentists licensed by credential that is not employed in a "clinic" setting was paid $26,007 by Medicaid for fee-for-service dental services. In 2003, one of the 51 dentists licensed by credential that is not employed in a "clinic" setting participated in the Northern Nevada Dental Health Program

(NNDHP.) Through NNDHP dentists provide pro bono services to Medicaid, Nevada Check Up and uninsured children. In 2003, Medicaid paid NNDHP $21,806 for fee-for-service dental services.

In FY02 the Bureau's Primary Care Development Center completed the redesignation of Dental HPSAs, determining 21 Dental HPSAs in Nevada that comprise most of the state. Nine are whole counties(Esmeralda, Eureka, Lander, Lincoln, Lyon, Mineral, Nye, Pershing and White Pine); 7 are partial counties (1 in Churchill, 4 in Elko, and 2 in Humboldt); and 5 are population based (4 in Clark County and 1 in Washoe). This did not change in FY03.

b. Current Activities

SPM #12: FY 04. The SHD has continued to partner with other organizations throughout the state to improve access to care. In FY 04 Health Access Washoe County (HAWC) Community Health Center opened a satellite dental clinic in Reno. Dental capacity at HAWC has increased to 16 dental operatories and 4 full-time dentists. HAWC is now the 4th largest provider of Medicaid fee for service dental services in the state. HAWC is implementing a special project to provide dental services to pregnant women. This project is being funded through a $50,000 grant the SHD received from HRSA/BPHS. A second $50,000 grant from HRSA/BPHC is being used to fund a program to recruit volunteer dentists to provide services to uninsured children in Clark County. Access has also improved in rural communities. Construction on community dental clinics has stared in Elko, Silver Springs and Yerington. These clinics will provide care to Medicaid and Nevada Check Up clients and offer a sliding fee scale. The Miles for Smiles mobile dental program is now providing services utilizing their mobile dental clinic to Elko, Lander, Humboldt, Eureka and White Pine Counties in Northeastern Nevada.

Two dental hygienists practicing in public health settings obtained Medicaid provider numbers in FY 04. Since the State Board of Dental Examiners adopted the rules change allowing hygienists to place dental sealants without a diagnosis from a dentist, a significant number of hygienists have indicated interest in obtaining a public health endorsement. Public health endorsement is necessary prior to obtaining a Medicaid provider number.

c. Plan for the Coming Year

SPM #12: FY 05. The Oral Health Program will continue its efforts to promote oral health in Nevada. The Oral Health Program staff will continue to work with Medicaid staff to promote participation of local dental providers in Medicaid.

The SHD will continue to work closely with oral health related projects funded by the Fund For A Healthy Nevada. Programs receiving funding from the Fund for FY 05 include Great Basin Primary Care Association, St. Mary's Foundation, Saint Rose Dominican Positive Impact Program, Miles for Smiles, Family Resource Centers of Northeastern Nevada, Saint Rose Dominican Positive Impact Program, White Pine School District and the Making Access Possible (MAP) Coalition. The Oral Health Program is providing technical assistance to all the funded projects.

The Oral Health Program will continue to work with the Primary Care Development Center to place dentists in underserved areas.

State Performance Measure 3: *SPM 14. The rate of child abuse and neglect should be reduced.*

a. Last Year's Accomplishments

SPM #14. The rate of child abuse and neglect should be reduced. FY 03: 5.0

Data for this performance measure numerator comes from the Division of Child and Family Services, and the denominator comes from State Vital Statistics, CHDR.

This is a population based state performance measure. Children should not be subject to abuse or neglect, and the Bureau has worked with the Division of Child and Family Services and the University of Nevada, Reno Cooperative Extension Agency to increase the awareness and screening of child abuse and neglect.

The Child Care Health Consultant trainer team has trained a class of selected child care health consultants to become knowledgeable about the many components of quality in child care and the realities of various child care settings, including screening for child abuse. These selected health care providers are becoming health consultants to child care programs. This training has been made possible by a CISS grant received by UNR. Follow-up training of child care health consultants will take place over the next two years. The Bureau's MCH supported Perinatal Nurse Consultant is the SHD's member on this team.

Bureau personnel also gave training to detect child abuse and neglect to health care providers. "Prevent Abuse and Neglect through Dental Awareness", "P.A.N.D.A.", which concentrates on oral injuries, is being given to dentists, oral hygienists and other health care providers. These trainings will continue to be available in the next year. The MCH Chief has offered the P.A.N.D.A. training by oral health staff to Head Start agencies in the State as they are looking for training on identification and referral of child abuse and neglect.

The Bureau has also developed and has been presenting a class to child care providers titled "Prevention of Illness, First Aid and Safety". Child care providers must learn first hand how to evaluate a child's health, including observing for signs of abuse. This training has been given over the past year to several providers across the state.
The Bureau Chief continued membership on the Title IV b Family Preservation and Support Committee. The Bureau Chief continued work to ensure MCH concerns are addressed in any changes to Nevada's Title IV-B program.

b. Current Activities

SPM #14: FY 04:

A second class to train Child Care Health Consultants (CCHC) was conducted recently in Southern Nevada. Screening for child abuse and neglect is part of the curriculum the CCHC's are taught. This information can then be used for the CCHC's to help child care facilities become more familiar with the signs and symptoms of abuse and neglect.

The Bureau has been collaborating with the Junior Leagues of Nevada to produce and distribute a state-wide, multimedia campaign titled "Safe Haven". The Safe Haven campaign is designed to educate the public about a new Nevada law that allows parents to leave a baby (up to 30 days of age) at any "safe haven". Safe havens are hospitals, fire stations, law enforcement agencies, obstetric centers and independent licensed centers for emergency medical care. The law provides that the parent/s will not face criminal prosecution if they leave their baby at a designated safe haven. It is hoped that with the education of the public and new parents, fewer cases of abandoned babies in unsafe places (such as dumpsters, toilets) will take place.

Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.), currently available in 44 states and six countries, provides training courses and materials to dental professionals and others regarding how to recognize, report, and prevent suspected child abuse and neglect.

Studies indicate that dentists are five times more likely to report suspected cases if they receive appropriate education in this area. In addition, P.A.N.D.A. is useful for anyone who works with or cares about children, e.g., all health care providers, child care staff, and family resource center staff, etc.

Nevada State Health Division, Oral Health Program has been conducting P.A.N.D.A. classes since bringing P.A.N.D.A. to Nevada in 2001. Since April 2001, over 60 classes have been conducted to more than 1100 people. Recently, a mailing was done to all licensed dentists in the state, offering the class free of charge to the dentists and staff. There has been a tremendous response to the program and we are continuing to provide classes. P.A.N.D.A. training also continues to be incorporated in the two dental hygiene schools in the state, as well as in the UNLV School of Dental Medicine, and the Pediatric Dental Residency in the UNLV School of Medicine.

c. Plan for the Coming Year

SPM #14: FY 05:

Future plans include continued collaboration with family violence advocates to educate the public and providers about child abuse and neglect.

The Bureau will be implementing the Early Childhood Comprehensive Systems grant. The activities of this grant include assessing for and planning what services all young children need to have a "seamless" system of care. Included in this system of care will be child abuse and neglect services.

The future activities of P.A.N.D.A. include offering the training to all health care providers, including students and residents, who have children under their care, child care providers, and any group or organization working with children and families. In addition, a survey is being developed to send out to participants several months after taking the class to determine the perceived effectiveness of the training, as well as actions taken to achieve the goals of P.A.N.D.A.

State Performance Measure 4: *SPM 16. Teen pregnancy rates among adolescents 15-19 should be reduced, with emphasis on minority populations.*

a. Last Year's Accomplishments

SPM # 16. The rate of birth (per 1,000) for teenagers aged 15 through 19 years. FY03: 4.8 per 1,000.

The data for FY 03 is from state birth certificates, CHDR database. This measure is population based.

Nevada maintained a multi-faceted approach to teen pregnancy. Using the Teen Pregnancy Action Plan as a guide, the State continued its aggressive strategies to spread the word on the challenges of teen parenthood.

Abstinence-only funds were not made available to community organizations in FY03, but will be made available in FY04. This is because Congress still had not re-authorized funding for abstinence-only education. Some community organizations have remained active using funds from other sources and the State continued to support them with technical assistance.

The Bureau and Southern Nevada Area Health Education Center (AHEC) collaborated on providing training for parents in the various issues of teen maturation and how to talk to their children. The curriculum used is Positive Choices, Positive Futures (PCPF)- Helping Parents Help Teens. The program was marketed in Northern Nevada, with little interest. Only 2 presentations were executed in Northern Nevada in FY03. AHEC has been successful in marketing the program and has reached a large number of Hispanic families.

The State Partnership to Prevent Teen Pregnancy supervised an RFP process in FY02, resulting in the awarding of contracts to programs promoting teen pregnancy prevention. The contracts were awarded for a social marketing campaign and 5 local project grants. Ogilvy Public Relations Worldwide executed the media campaign in SFY03 with success. The local project grants were awarded August 2002, and continue through June 30, 2003. Two grant recipients focused their teen pregnancy prevention efforts on minority populations. The TANF funding was notavailable for another RFP process in FY04.

The Governor's Youth Advisory Council (YAC) continued to perform "Abstinence Works!" to 9-14 year old youth in Nevada. In FY03, over 1,000 of Nevada's youth viewed the program. The program was well received in Nevada's rural areas, which typically have a high rate of teen pregnancy.

Additions were made to the Teen Pregnancy Prevention Resource Center, keeping it current. Materials in this Center were made available to community organizations and other interested parties upon request.

A new contract was completed between the State Health Division and the Nevada Broadcasters Association for the abstinence-only media campaign. That campaign began at the end of FY03, and will continue until the end of FY04. The campaign consisted of radio and television non-sustaining commercial announcements.

b. Current Activities

SPM # 16: FY04. The main activities for Nevada's teen pregnancy prevention initiative include community involvement through community organizations, the Nevada Statewide Coalition Partnership, which is a network of prevention coalitions located in ten of Nevada's seventeen counties, workshops for parents of adolescents, and the continuation of the Governor's Youth Advisory Council, which has identified teen pregnancy prevention as its top priority.

Due to Congress reallocating funds to the States based on Census 2000 data, Nevada is being given nearly double the Abstinence-Only funds in FY04 than FY03. The majority of the increased funding is being made available to the community organizations via an RFP process. These funds are targeted towards the Hispanic/Latino populations of Clark and Washoe counties which are the states most populous counties with the highest rates of teen pregnancy.

Some funds are also being used to promote parental communication and connectedness throughout the State. Two RFPs are being administered to provide training for parents in the various issues of teen maturation and how to talk to their children. Positive Choices, Positive Futures is a popular program in Southern Nevada as the Southern Area Health Education Center has been successful in marketing it. An attempt to replicate the program in Northern Nevada is currently being explored.

Materials in the Teen Pregnancy Prevention Resource Center are available to community organizations and other interested parties upon request. The State Health Division maintains

the State Teen Pregnancy Prevention website: http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public.

Bureau staff continues to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. Currently an initiative to combine efforts to prevent STDs, HIV and teen pregnancy by addressing common risk factors as well as promoting protective factors is underway. This initiative is a collaboration between the State Department of Education, the State Division of Mental Health and Developmental Services, the State Division of Child and Family Services, the State Welfare Division, and the State Health Division's Bureau of Family Health Services, Bureau of Community Health, and Bureau of Alcohol and Drug Abuse.

The media campaign with Nevada Broadcasters Association is continuing until September 2004. At that time a new contract will be considered.

The GYAC continues their "Abstinence Works!" presentations on a limited basis. The GYAC is currently evaluating the program in order to decide if they will continue it with revisions, which include a stringent evaluation component, or pursue the use of another (research based) program, to expose more school aged children to the abstinence message.

c. Plan for the Coming Year

SPM # 16: FY05. The main activities for Nevada's teen pregnancy prevention initiative will include community involvement through community coalitions, a statewide media campaign, workshops for parents of adolescents, more collaboration between state agencies, and the continuation of the GYAC,which has identified teen pregnancy prevention as its top priority.

Due to Congress reallocating funds to the States based on Census 2000 data, Nevada will continue to receive increased Abstinence Education funds in FY05. The majority of the increased funding will be made available to community coalitions and non-profit organizations through a RFP process. Due to the diverse structure of Nevada's communities, abstinence funds will be subcontracted to local organizations for use in local interventions. Two subcontracts will be awarded to support programs that educate parents of adolescents, and two will support programs that focus on teen pregnancy prevention for Hispanic/Latino adolescents in Nevada's two most populous counties, Clark (including Las Vegas) and Washoe (including Reno and Sparks).

Materials in the TPP Resource Center are available to community organizations and other interested parties upon request. The SHD maintains the State TPP website: http://health2k.state.nv.us/CAH/teenpregprevention.htm which offers resources to the public as well.

Bureau staff will continue to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. Staff will continue collaborating with local programs such as the Clark County Teen Pregnancy Prevention Coalition. The program will also continue to support two teen clinics residing in both Clark and Washoe Counties. In addition SHD staff will collaborate with other state programs to collectively address teen pregnancy prevention. For example, the SHD will continue collaborating with the State Department of Education, the State Division of Mental Health/Developmental Services, the State Welfare Division, and the State Division of Child and Family Services to reduce the incidence of STDs, HIV and teen pregnancy.

The contract with Nevada Broadcasters Association for the teen pregnancy prevention media

campaign will be renewed for two more years when it expires September 2004. The dollar amount of the contract will be lessened in order to make more funding available for community programmatic efforts. The Nevada State Health Division will also support the statewide media campaign by printing ads in local newspapers during teen pregnancy prevention month that encourage communication between adolescents and parents.

The GYAC will reevaluate their "Abstinence Works!" presentation for effectiveness and decide if the program should be continued. The GYAC will be presesented with additional programs that could possibly be implemented.

State Performance Measure 5: *SPM 17. Access to specialty and subspecialty services available to CSHCN should be increased.*

a. Last Year's Accomplishments

SPM 17. FY03: 86.9/1,000.
The data source for this measure is the CHDR vital statistics, PCDC's State Physician's Survey, and the Burearu's physician database. This measure is related to priority 7, access of CHSCN to specialty and sub specialty care.

Historically, in Nevada, the CSHCN Program was the primary source of specialists and sub-specialists for children. Providers, state agencies and advocacy organizations referred and collaborated with the program to serve children. For many years, there were a limited number of specialists and sub-specialists in the state. This was primarily due to the relatively small population of the urban areas and the sparse population of the rural areas.

Physicians in Nevada frequently referred to specialists out of state in order to access the specific services needed by a patient. Families needed to travel long distances to ensure that their child received appropriate services, and the CSHCN Program provided assistance in a variety of ways including information and referral to Medicaid, county assistance programs, insurance advocacy, funding for travel, referral to specialty clinics, payment for services, and linkage with volunteer organizations. Follow up services locally was often a problem and families were forced to travel long distances. The CSHCN Program sponsored specialty clinics during that time for such specialties as cleft/craniofacial, metabolics, and genetics to assure that families had local access to specialists. CSHCN contracted with specialists from out of state to come to Nevada and provide clinical consultation.

E.I. Clinics offering multi-disciplinary evaluations, referred to the CSHCN Program and to specialty clinics when indicated, thus assuring that children already identified as CSHCN receive appropriate services. Specialty clinics served a total of 526 CSHCN. The State Newborn Screening and Newborn Hearing Screening programs refer to the CSHCN Program and specialty clinics as well, thus building a more "seamless" system of services for families and services providers of CSHCN.

In FY03, there were 579 specialists serving 6,663 CSHCN, of which only 72 were pediatric specialists. This is an increase in the number of specialists serving CSHCN.

b. Current Activities

SPM 17. FY04. The CSHCN Program continues to provide specialty clinic services to children Statewide. The services span a wide scope of specialties including Cranio-facial, Metabolic, and Genetics. Children needing other types of services are referred to providers in the local private sector who have agreed to accept CSHCN program coverage. Children eligible for Medicaid and Nevada Check Up agreed also seen by this same group of providers. CSHCN

staff continue to provide advocacy for families during the eligibility process for both the Medicaid and Nevada Check Up programs.

Despite the national healthcare crisis regarding physician liability issues, those providers seeing CSHCN have continue to provide services to clients. CSHCN staff work with providers to clarify program coverage, reimbursement and claims resolution in order to maintain a healthy "working relationship" with each provider and their office staff. Families are advised of program coverage and limitations as well, thus providing an improved atmosphere of trust between provider and patient. Staff advocate with private insurers for coverage of specific services that may be a "bit out of the ordinary", but directly related to a diagnosis that may be very rare. CSHCN staff provide information to insurers regarding the diagnosis, and also provide literature to providers unfamiliar with a specific disorder. The CSHCN program authorizes office visits with sub-specialists if necessary to clarify the causes, symptoms and treatment that will be necessary in some rare disorders within this population. These activities have been successful in promoting an ongoing working relationship with providers and families in keeping specialty services accessible. Providers, and families, call the CSHCN Program to access information relative to assisting with contacting consultants, assistive devices, hearing aides, eligibility for Medicaid/Nevada vCheck Up, and advocacy with private insurance.

c. Plan for the Coming Year

SPM 17. FY05 CSHCN staff will continue to work with families and providers to ensure access to appropriate specialty services. Contracts with specialists are in place so children will continue to have needed services available locally. Specialty clinics for genetics, metabolic and cleft/craniofacial conditions will continue. Staff will continue to work with families to assist with the eligibility process for Medicaid and Nevada Check Up, County programs, and community organizations, as well as provide advocacy services with private insurance carriers to assure service coverage.

Plans are to continue working with the E.I. clinics and enhance collaboration with the other components of E. I. that are within the new Bureau of Early Intervention (E.I.) Services. The CSHCN specialty clinics including metabolic and genetics will continue to be situated at the E.I. sites.

CSHCN, Medicaid and Nevada Check Up staff will continue to work to create a data linkage that will help Medicaid identify CSHCN enrolled in HMOs. Medicaid and Nevada Check Up HMO's are charged with ensuring CSHCN receive all the services they need, as HEIDIS requirements are in place.

State Performance Measure 6: *SPM 18. Access to services that assist CSHCN in care coordination, respite, outreach, case management, & coordination with Medicaid, Nevada Check Up or purchase of health insurance should be increased*

a. Last Year's Accomplishments

SPM 18. FY03. 542.9/1,000. Data for this measure is from the CHDR's vital statistics, BFHS caseload, SCC's Medicaid and Nevada Check Up, and the state demographer. This measure is related to priority 7, access to specialty and sub-specialty care, and priority 8, access to quality day care.

CSHCN in Nevada received care coordination services through the CSHCN Program and the E.I. clinics in Las Vegas and Reno. E.I. services provided multi-disciplinary diagnostic evaluations and made recommendations and referrals for extended physician, physical, occupational, and speech therapies, as well as for a variety of mental health and

developmental services. CSHCN referred from other sources were advised of the availability of specialty clinics supported by CSHCN. Many of the children received extended treatment at the clinics, while receiving ongoing evaluation of their progress. In those cases of children needing more services, staff determined eligibility and assisted families in accessing Medicaid, Nevada Check Up, Shriner's, and other community and advocacy organizations.

The CSHCN Program provided care coordination to all children eligible for the program. Medical services being requested are reviewed for program eligibility and appropriateness. Only services provided by "qualified" providers are approved, thus ensuring quality service delivery. Staff worked with providers to ensure that the children receive needed care and that PCP's provide ongoing follow up evaluation and treatment. Staff also provide information, referral and advocacy for all those referred, even those not directly eligible for program coverage. Staff maintained a provider list of specialists and sub-specialists who work with CSHCN, as well as lists of equipment suppliers, community organizations, advocacy groups and volunteer groups that assist families of CSHCN. Families received assistance in "navigating the system" regarding Medicaid and Nevada Check Up eligibility and advocacy information pertaining to private insurance coverage.

b. Current Activities

SPM 18. FY04. The CSHCN Program continues to provide care coordination and enabling services to families. Staff assist families with the eligibility process for other programs such as Medicaid and Nevada Check Up, and provided advocacy for families with private insurance. They also work with the families and insurance to clarify the children's conditions and the recommended treatment, thus ensuring that CSHCN receive timely and appropriate services for "unusual" conditions.

Families in need of assistance with travel, lodging, respite, and mental health services receive information and referral as to how to access these services in the community. CSHCN needing "specialty" services are referred to the specialty clinics supported by the CSHCN Program or are referred to specialists in the area who are CSHSN providers. CSHCN staff also worked with Shriner's in providing ancillary services, and ensuring specialty follow-up care and with the PCP in Nevada. To ensure that families have a community contact, referrals from out of state are linked with local community health nurses. CSHCN provide families with linkages to community organizations, parent advocacy groups such as Family Ties and E.I. clinics, which have support groups in place.
The SHD was awarded a Real Choice Systems Change grant that provides support for the development of a needs assessment to more clearly define areas of service and location that are in need of improvement regarding CSHCN services in Nevada. The RCSC team is working contracting with the vendor to perform the statewide needs assessment. They are also working on developing a "Nevada Advisory Council on CSHCN" that will be given decision making authority in the direction and content of RCSC project activities.

c. Plan for the Coming Year

SPM 18. FY05. The CSHCN Program will continue efforts to provide up to date information for families relative to community resources available. Staff will continue to update files of available specialists and equipment suppliers willing to work with CSHCN, and will provide information and assistance to PCP's trying to access services for patients. Staff will continue to work with Medicaid and Nevada Check Up staff to better identify CSHCN within their programs, to ensure that children receive needed medical services, and to clarify conditions needing specialty services. As Medicaid and Nevada Check Up enroll children in managed care organizations, CSHCN will provide input into criteria for coverage of specific conditions to ensure that all children, especially CSHCN, receive quality and appropriate medical care. E.I.

diagnostic and treatment services will continue to be available to all CSHCN to assure that they receive the full scope of needed care and are able to reach appropriate developmental milestones. Staff works with the Department of Education to assure children transition into the special education programs within school districts. Plans are to enhance this collaboration to improve transitions to adulthood for CSHCN and develop enhanced vocational training plans. This will be a continued focus of the CSHCN Program's efforts in advising parents of the importance of their input in developing a medical, social, and educational plan for their child's future.

Contracts with specialists to provide specialty clinic services are in place, and CSHCN will be referred and followed as needed. Families in need of advocacy services with private insurance, Medicaid, Nevada Check Up, Shriner's, and other community resources will receive staff assistance relative to eligibility, special procedures, ongoing treatment, and needed support/ancillary services. CSHCN staff plans to enhance their collaboration with the Family Ties organization by linking them with patients, families, and other groups working for improved services in Nevada.

Plans are to implement the first phase of the Real Choice Systems Change grant. Staff will work on the completion of a needs assessment and will work on the creation of the "Nevada Council on CSHCN". Activities will include involving eh Council in all aspects of the project and ensuring that member involvement will continue after the funded project activities have been completed.

State Performance Measure 7: *SPM 19. The percent of children and youth (ages 0 - 21) and women of child-bearing age and CSHCN who have homes for primary medical care, regardless of ability to pay, should be increased.*

a. Last Year's Accomplishments

SPM 19: FY 03: 2.1 (primary care providers per 1,000 children, youth, women of childbearing age, and CSHCN ages 0-19). This figure is up from 2.0 in FY 02. The basis for this measure is the ratio of primary care providers available in the State to the number of children, youth, women of childbearing age (15-44), and CSHCN ages 0-19 in Nevada who had a medical home. Homes for primary medical care is interpreted to include persons who are covered by medical insurance. The ratio was 1,768 primary care providers to 854,021 target population who had a medical home. The uninsured estimates are from the most recent reliable report regarding Nevada's uninsured - a 2002 "Uninsured Persons in Nevada" study conducted for GBPCA through funding by BFHS's Primary Care Development Center (PCDC). The estimates for the population subgroups are from the Nevada State Demographer's Office as of July 1, 2003. This measure relates to priority 10, access to primary care.

Efforts to improve this measure are related to Infrastructure Services in terms of the Performance Measurement System. SPM 19 overlaps NPM 13. The most important efforts in FY 03 related to this measure involved three major ongoing activities:
1. Substantial increase in enrollment in the State Medicaid Office's Nevada Check Up program.
2. Public and private programs targeted to women and children; i.e. Special Childrens Clinics, WIC.
3. Improvement of the primary care safety net to promote access to care, particularly for the uninsured.

Ongoing activities through the Bureau's Primary Care Development Center (see NPM 13) continued to contribute to improvement of the primary care safety net, which helped to increase access to and the availability of primary care providers throughout the state, most

noticeably in medically underserved areas. PCDC activities included designating health professional shortage areas, placing NHSC and SEARCH providers in underserved area, providing financial and technical support for community development activities related to primary care. Key partners for PCDC include Great Basin Primary Care Association, University of Nevada School of Medicine, Nevada Health Centers, Nevada Rural Hospital Partners, and the Office of Rural Health.

b. Current Activities

SPM 19: FY 04. Nevada Check Up program increased enrollment during FY 04 from 24,687 in April 2003 to almost 27,006 in May 2004. Regarding primary care physicians (PCPs), it appears that the increase of new PCPs in FY 04 offsets the increase in the population of the target groups.

All of the BFHS programs and services that contributed to SPM 19 in FY 03 continued to be carried out in FY 04. BFHS activities targeted to women and children that contributed to this performance measure included CHSCN, Baby Your Baby/MCH Campaign, WIC and Early Intervention services. The contribution of public and private programs targeted to women and children was also discussed in preceding section concerning NPM 13.

Ongoing activities through PCDC (see NPM13) continued to promote improvement of the primary care safety net, which served to increase access to and the availability of primary care providers throughout the state, most noticeably in medically underserved communities. PCDC continued to provide financial and technical support for community development activities related to primary care such as the Washoe County Access to Healthcare Network and the Clark County Health Access Consortium.

c. Plan for the Coming Year

SMP 19: FY 05. In FY 05 Nevada Check Up, which the Bureau actively supports, is expected to continue to increase enrollment and thereby reduce the number of uninsured children and youth. It is also anticipated that the gradual improvement in the economy will enable persons including the target group of women of child bearing age to become insured. BFHS is in the forefront of the other three main activities which constitute the key efforts toward expansion of the Nevada Check Up Program to increase enrollment for children including efforts of RCSC detailed in NPM 4.

BFHS will continue to carry out its ongoing activities outlined above, all of which contribute to helping offset the obstacles to care related to a lack of primary care homes for children, youth, women of childbearing age, and CHSCN.

Through the programs it administers PCDC will continue its efforts in FY 05 to enhance the primary care safety net as a significant approach to mitigating limitations to care related to lack of medical insurance. One major new target area in FY 05 related to access to care is Elko, where those who live there and need care from a safety net provider must drive to Carlin for that care.

State Performance Measure 8: *SPM 20.The percent of children and youth (ages 0-21), women of child-bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased.*

a. Last Year's Accomplishments

SPM # 20. FY 03: 1.9%

The numerator (mental health personnel) is from the State Mental Health Division (state employees) and the PCDC (non-state employees). The denominator is from Census data and State Demographer estimates. This measure is related to priorities involving teen pregnancy, substance abuse, and child abuse and neglect. Mental health plays a role in all these measures.

Children's' mental health continued to be a BFHS priority. MCH supported this effort through promoting intended and healthy pregnancies, promoting healthy lifestyles and acceptance of personal responsibility, participation in the steering committees for family preservation and support and child care, implementation of child abuse reporting (see SPM # 14), and access to health care and other services for Nevada's MCH populations. Mental Health was identified as one of the MCH Five Year Needs Assessment priorities.

PCDC is grantee for the Quentin Burdick Program for Rural Interdisciplinary Training. The program involves teams of students carrying out community health projects during 13 week training rotations in communities throughout Elko County. Mental health services are a major emphasis of the program.

PCDC is responsible for the designation of mental health Health Professional Shortage Areas (HPSA) in medical underserved communities. Designations help with recruitment and placement of mental health providers in underserved areas. Among Nevada's 17 counties 12 entire counties are designated as mental health HPSAs, one is partially designated, and four are not designated.

The Child and Adolescent Health program began developing a state team to address adolescent health. Included on this team is a representative of the Division of Mental Health and Developmental Services and the Division of Child and Family Services, both of which provide mental health services in Nevada. With their inclusion, mental health issues affecting Nevada's adolescents are being included in all adolescent health initiatives.

The State Health Division, Bureau of Family Health Services received an Early Childhood Comprehensive Systems grant in fiscal year 2003. The purpose of this grant is to develop a statewide plan to create a seamless service delivery system for children from birth to five that will fill all service gaps including access to mental health services.

b. Current Activities

BFHS continues to carry out a range of activities which directly and indirectly benefit the target populations for this measure in relation to improving access to mental health services.

The Division of Child and Family Services undertook the establishment of neighborhood centers in Clark County with mental health, community outreach, and early intervention coordinators. The Bureau of Early Intervention Services (BEIS) moved to the Health Division in FY 04. BEIS clinics are located in the Neighborhood Centers. Early Intervention services will stay co-located with mental health services in Las Vegas and directly across in Reno.

In FY 04 PCDC re-designated six entire rural counties as mental Health HPSAs. PCDC placed one foreign medical graduate J-1 Visa psychiatrist in a State clinic in Las Vegas.

PCDC also helped to place two psychologists and four social workers in medically underserved areas through the National Health Service Corps. PCDC's Quentin Burdick program continued to carry out health-related projects in four Elko County communities.

The Child and Adolescent Health program is continuing to include mental health in all of its efforts. A state-wide team is being assembled by the Early Childhood Comprehensive Systems program and will be addressing ways to improve access to mental health services

c. Plan for the Coming Year

The Quentin Burdick Interdisciplinary Training program will not continue in FY 05 as it was not refunded. Mental health services will remain a priority and the Bureau will continue to work with the University to develop mental health services in rural communities.

PCDC will continue to designate Mental Health HPSAs, MUPs and MUAs throughout the State and help to place mental health professionals in medically underserved communities through the J-1 Visa Waiver program and the National Health Service Corps.

The Child and Adolescent program will continue to explore ways to include mental health in all initiatives and increase access to services. The Early Childhood Comprehensive Systems program will continue to develop a statewide plan, including activities to address access to mental health services by children and their families.

The Division of Family Health Services (DCFS)will be applying for a State Infrastructure Grant (SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address adolescent mental health and substance abuse issues.The Bureau is partnering with DCFS in this effort in both the development of the grant application and identifying activities that would tie to Bureau efforts such as teen pregnancy and violence prevention should the grant be funded.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) SPM 11. The percent of women of child-bearing age who need assistance and receive it for domestic violence from an agency or shelter should be increased.				
1. Continue promoting the statewide domestic violence health screening protocols.	☐	☐	☑	☐
2. Conducting on-going training classes to health care providers.	☐	☑	☐	☐
3. Establishing "expert witness" protocols for use in court.	☐	☐	☑	☐
4. Collaborate with a variety of agencies to educate the public about domestic violence.	☐	☐	☑	☐
5. MCH will serve on the Nevada Attorney General's Domestic Violence Prevention Council.	☐	☑	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) SPM 12. The percent of women, children, and youth (ages birth to 21) who have access to preventive oral services and dental care, regardless of ability to pay, should be increased.				
1. Continue to work with Medicaid staff to promote participation of local dental providers in Medicaid.	☐	☑	☐	☐
2. Continue to work closely with GBPCA to recruit dental providers interested in providing dental services to underserved communities and populations in the State.	☐	☑	☐	☐
3. Continue to provide technical assistance to all the Task Force for a Healthy Nevada funded projects.	☐	☑	☐	☐
4. Continue to assist dentists in locating underserved communities in which to practice.	☐	☑	☐	☐
5. Continue to work with the Primary Care Development Center to place dentists in underserved areas.	☐	☑	☐	☐
6. Continue to develop oral health surveillance system to guide program efforts.	☐	☐	☐	☑
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) SPM 14. The rate of child abuse and neglect should be reduced.				
1. The Bureau will conduct training classes to child care health consultants on child abuse & reporting	☐	☑	☐	☐
2. The MCH program collaborates with agencies to educate the public about child abuse and reporting.	☐	☑	☐	☐
3. The Bureau will continue to work with University Nevada Reno to train child care health consultants.	☐	☑	☐	☐
4. The Bureau has and will continue to give P.A.N.D.A. training to medical, dental and other providers.	☐	☑	☐	☐
5. The Bureau will work with Junior Leagues of Nevada to promote "Safe Haven" campaign for infants who would be abandoned in trash, toilets etc.	☐	☑	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

4) SPM 16. Teen pregnancy rates among adolescents 15-19 should be reduced, with emphasis on minority populations.				
1. Maintenance of TPP webpage and resource center	☐	☐	☑	☐
2. GYAC's continued commitment to teen pregnancy prevention via keeping TPP as their top priority.	☐	☐	☑	☐
3. Support CATs with federal Abstinence-Only Education funds for contracts for A-O programs.	☐	☑	☐	☐
4. Continuation of a statewide media campaign with NBA promoting sexual abstinence until marriage.	☐	☐	☑	☐
5. Continuation of workshop for parents of adolescents, teaching them importance of healthy sexuality.	☐	☑	☐	☐
6. Continuation of statewide "A W!" presentations or its successor, a program for 9-14 year olds on importance of abstinence.	☐	☑	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) SPM 17. Access to specialty and subspecialty services available to CSHCN should be increased.				
1. CSHCN staff will continue to work with families and providers to ensure access to specialty services	☐	☑	☐	☐
2. CSHCN will continue contracts with specialists so children will have needed services available.	☐	☑	☐	☐
3. CSHCN staff will work with families to assist with the eligibility process for Medicaid & Check Up.	☐	☑	☐	☐
4. CSHCN staff will provide advocacy services with private insurance carriers to assure coverage.	☐	☑	☐	☐
5. CSHCN staff will provide information & training for new E.I Bureau staff on collaboration w/CSHCN.	☐	☑	☐	☑
6. CSHCN will continue to pay for treatment for eligible CSHCN.	☐	☑	☐	☐
7. CSHCN staff will work with Medicaid to identify CSHCN in HMOs for coverage under capitated rate.	☐	☑	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) SPM 18. Access to services that assist CSHCN in care coordination, respite, outreach, case management, & coordination with Medicaid, Nevada Check Up or purchase of health insurance should be increased				

1. CSHCN Program will provide up to date information for families relative to community resources etc.	☐	☑	☐	☐
2. CSHCN Program will provide information & assistance to PCPs trying to access services for patients.	☐	☑	☐	☐
3. Staff will work with Medicaid,Nevada Check Up staff to better identify CSHCN within those programs.	☐	☑	☐	☑
4. Staff will work with Medicaid and Nevada Check Up to clarify conditions needing specialists.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) SPM 19. The percent of children and youth (ages 0 - 21) and women of child-bearing age and CSHCN who have homes for primary medical care, regardless of ability to pay, should be increased.				
1. Support for expansion of the Nevada Check Up Program to increase enrollment for children.	☐	☐	☑	☐
2. Improvement of primary care safety net to promote access to care for uninsured through designations.	☐	☑	☐	☐
3. Financial and technical support for community development activities related to primary care.	☐	☑	☐	☐
4. Work with public and private programs targeted to women and children that refer to covering programs	☐	☑	☐	☐
5. Monitor and ameliorate the medical malpractice crisis of OB/GYN services will continue.	☐	☑	☐	☐
6. Monitor and ameliorate malpractice crisis on access to medical specialists for CSHCN.	☐	☑	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) SPM 20.The percent of children and youth (ages 0-21), women of child-bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased.				
1. PCDC will continue to designate Mental Health HPSAs, MUPs and MUAs.	☐	☑	☐	☐

2. Early Intervention services will stay co-located with mental health services in Las Vegas and Reno.	☐	☑	☐	☐
3. The interdisciplinary training in Wendover, Carlin and Jackpot will end; the Bureau will seek other ways to continue it.	☐	☑	☐	☐
4. PCDC will continue to conduct the survey of mental health services to establish designations.	☐	☐	☐	☑
5. The Child and Adolescent program will partner with DCFS for a SAMSHA grant to address mental health and substance abuse in adolescents.	☐	☐	☐	☑
6. Early Childhood Comprehensive Systems Development will address access to mental health services as part of the statewide plan.	☐	☐	☐	☑
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

E. OTHER PROGRAM ACTIVITIES

There has been no major change from last year's application. Early Intervention was moved into a new Bureau of Early Intervention Services within the SHD. This moved the supervision of E.I. services from the MCH Chief to the new Bureau.

The Nevada WIC program has been piloting an Electronic Benefit Transfer (EBT) system for the provision of WIC benefits to participants in Washoe County. Nevada is now ready to do a state-wide roll-out of WIC EBT; this should be accomplished in FY05 or FY 06 at the latest. With EBT participants can go to any WIC vendor for their groceries, and only have to take what they need at the time. Vendors do not have to worry about out of compliance purchases that lead to vendor fines, as foods are accepted or rejected electronically and do not rely on the grocery clerk's knowledge of WIC.

All activities of Nevada MCH are included one way or the other in performance measures and are recorded within the National and State Performance Measures Sections. If they are not included, they are not addressed by Nevada MCH. This includes purchase of health insurance, and applied research, all listed in the Pyramid. As previously noted, WIC is part of MCH.

There is one change in Nevada's three toll-free hot-lines. The first MCH/CSHCN toll-free number is now 1-866 254-3964. The second and primary line is the MCH Campaign's 1-800-429-2669. In CY 2003 when it was still Baby Your Baby the BYB IRL had 7,573 calls. Reports in future years will be on the MCH Campaign.

The third line is part of a WIC/Immunizations/Medicaid promotion. Its number is 1-800-8 NEV WIC. It is discussed under NPM 7. All three lines are widely marketed. The MCH Campaign and WIC lines are answered through the Bureau, are both bilingual English and Spanish, and are included in multi-media bilingual campaigns.

F. TECHNICAL ASSISTANCE

Nevada's priority for this year is technical assistance on dealing with health disparities. The disparity in African American birth outcomes in particular is alarming. Linking to successful initiatives that address health disparities would be very helpful.

Nevada's cultural competency training for Bureau staff and others who work with MCH is a priority left

over from last year. Such training should be a follow-up to the training offered in 1999 through the National Center for Cultural Competency that was not very well received by staff. The Bureau has identified a Local source for the training at the University of Nevada Reno and is only awaiting word that technical assistance funds are available. In 2004 the Bureau is still awaiting word.

Another request as it was last year is for Best Practices in program evaluation, to be used in grant development, legislative inquiries, etc. It would help answer questions of is this a good use of state resources (or federal), what will it take to have credible findings, who should be involved, how can local data be standardized to promote statewide evaluation, etc. The Bureau would need assistance identifying a resource for this Technical Assistance. As this is a project of the Association of Maternal and Child Health Programs, perhaps some of their work would pertain to this request.

V. BUDGET NARRATIVE

A. EXPENDITURES

Form 3, State MCH Funding Profile shows FY 2003 MCH expenditures amounted to $1,536,682 with the appropriate expenditure match of state funds adhering to the required 3-4 match of three (3) state dollars for every four (4) federal dollars. The State expenditure amount was $1,152,512 for a total of $2,689,194. The MCH budget for FY 2003 was $2,927,628, so expenditures were $238,434 less than budget, or 8.1% of the budgeted amount. Other federal funds expended during FY 2003 amounted to $32,862,500. This compares with the budgeted amount of $31,788,074 to exceed budgeted expenditures by 3.4%. For FY 2003 the total budget under the guidance of the MCH Chief was $34,715,702 and expenditures under the guidance of the MCH Chief amounted to $35,551,694, which exceeded budget by $835,992, or 2.4%.

Form 4, Budget Details By Types of Individuals Served provides the detail for budget expenditure variances by population served. Pregnant Women included budgeted expenditures of $1,102,329 and actual expenditures amounted to $1,044,069 in FY 03. The budget expenditure variance for Pregnant Women is $58,260, or 5.3% below the amount budgeted. Expenditures for the Pregnant Women population included newborn screening expenditures. Federal expenditures for Pregnant Women amounted to $201,848, or 13.1% of federal funds expended in FY 2003.

Form 4 for FY 2003 for Children 1 to 22 Years Old included budgeted expenditures of $833,289 and actual expenditures amounted to $688,366. The budget variance for this group is a decrease of $144,923, or 17.4% below the amount budgeted. This decrease is explained by the reporting methods used for FY 2003 that included State expenditures for newborn screening being assigned to the Pregnant Women group. Federal expenditures for Children 1 to 22 Years Old amounted to $504,048, or 32.8% of federal funds expended in FY 2003.

Form 4 for FY 2003 for Children with Special Health Care Needs included budgeted expenditures of $833,289 and actual expenditures amounted to $778,997. The budget variance for this group is a decrease of $54,292, or 6.5% below the amount budgeted. This decrease is due to efforts by the state to concentrate expenditures for the Children with Special Health Care Needs population for direct services in the Nevada Early Intervention Services Bureau. Federal expenditures for Children with Special Health Care Needs amounted to $653,024, or 42.5% of federal funds expended in FY 2003.

Form 4 for FY 2003 for Administrative costs, included budgeted expenditures of $158,721 and actual expenditures amounted to $177,762. The budget variance for this group is an increase of $19,041, or 12.0% above the amount budgeted. This increase is explained by the fact the amount budgeted was less than the authorized 10% of the total grant for Administrative expenditures. The $177,762 was less than the 10% threshold for Administrative expenditures per grant guidance.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Direct Health Care Services for FY 2003 included budgeted expenditures of $1,718,518 and actual expenditures amounted to $1,018,179. The budget variance for this group is a decrease of $700,339, or 40.8% below the amount budgeted. This decrease is partially explained by the reporting methods used for FY 2003 that included State expenditures for newborn screening being assigned to the Population-Based Services group. Federal expenditures for Direct Health Care Services amounted to $607,063, or 39.5% of federal funds expended in FY 2003.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Enabling Services for FY 2003 included budgeted expenditures of $875,361 and actual expenditures amounted to $623,936. The budget variance for this group is a decrease of $251,425, or 28.7% below the amount budgeted. This decrease is explained by the fact expenditures for FY 2003 did not rise to the budgeted amount. Expenditures for Enabling Services did increase, however, by $118,626 from FY 2002 to FY 2003. Federal expenditures for Enabling Services amounted to $532,436, or 34.6% of federal funds expended in FY 2003.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Population-Based Services for FY 2003 included budgeted expenditures of $79,046 and actual expenditures amounted to $761,622. The budget variance for this group is an increase of $682,576, or 863.5% above the amount budgeted. This increase is explained by the reporting methods used for FY 2003 that included State expenditures for newborn screening being assigned to the Population-Based Services group from the Direct Services group. Federal expenditures for Population-Based Services amounted to $111,726, or 7.3% of federal funds expended in FY 2003.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Infrastructure Building Services for FY 2003 included budgeted expenditures of $254,703 and actual expenditures amounted to $285,457. The budget variance for this group is an increase of $30,754, or 12.1% above the amount budgeted. This increase is explained by the reporting methods used for FY 2003 that included 100% of Administration expenditures being assigned to this group as well as a percentage of Personnel costs based on the estimated amount of their time spent on activities including Planning, Policy Development and Coordination. Federal expenditures for Infrastructure Building Services amounted to $285,457, or 18.6% of federal funds expended in FY 2003.

B. BUDGET

This FY 2005 MCH application budget adheres to the required 3-4 match of three (3) state dollars for every four (4) federal dollars. The federal MCH portion is estimated, for budget planning purposes at $2,146,035 and is based upon $1,996,035 in FY 04 allocation and an anticipated carryover of $150,000 from the FY 04 allocation. The state MCH match, budgeted at $1,497,027 is comprised of State General Fund dollars and fees generated by the Newborn Screening program. The state MCH is for the current year allocation as the state match for the carryover was expended during the current fiscal year. The total FY 05 MCH budget is $3,643,062. As required, the FY 05 MCH budget complies with the FY 89 Maintenance of Effort amount. This amount represents $853,034.

For FY 05, 30.0% of the federal Title V allocation is directed to Section A of Form 2,Component B, preventive and primary care for children and adolescents that amounts to $598,811. Direct services provided under Component B are primary care and oral health oriented, as these represent two significant unmet needs for children and adolescents. Services are provided through community based non-profit agencies, as well as through the health districts in Clark County and Washoe County. In addition to direct services, Component B includes funding for the continued development of core public health/infrastructure activities including oral health and teen pregnancy prevention to ensure appropriate and continued services to children and adolescents.

For FY 05, 30.0% of the federal Title V allotment is directed towards Children with Special Health Care Needs, Section B, Form 2, Component C. The allotment budgeted for Component C services amount to $598,811. The individuals to be served under Component C are children with special health care needs and their families. Services funded under this component are primarily enabling services and are designed to be family-centered, community based, culturally appropriate and comprehensive. Direct services are provided through several mechanisms: through the Nevada Early Intervention Services and through health professionals, such as pediatric ophthalmologists and physical therapists who are under contract to the CSHCN program and the CSHCN treatment program. In FY 05 all these services are provided through the Nevada Early Intervention Services in Reno and Las Vegas and CSHCN staff based in Carson City. They will also support the pilot projects for CSHCN systems of care in Nevada that will be developed by the Real Choice Systems Change grant project.

For FY 05, Administrative costs, Section C, Form 2, will not exceed $199,603, which is 10% of the current period grant request total. For FY 05, the remaining federal Title V allotment is directed towards services for pregnant women and postpartum women and infants up to age 1 year. The allotment budgeted for services is $598,810. The individuals to be served are pregnant and

postpartum women and infants up to age 1 year statewide. Services are designed to be family-centered, community based, culturally appropriate and comprehensive. Direct services are provided through contracts with local agencies, including health districts and community based non-profit agencies. In addition, funding includes the continued development of core public health/infrastructure activities. The integration of perinatal substance abuse services including prevention of fetal alcohol syndrome into routine perinatal services received by all pregnant women is an example of the core public health activities to be continued in FY 05. A newly proposed breastfeeding initiative of the American Academy of Pediatrics will be supported through this component. Also included is the State's Newborn Screening program, which screens almost every infant born in the state for inborn errors of metabolism and hemoglobinopathies. The mandated newborn hearing screening passed during the State's 2002 Legislature (those born at hospitals with over 500 births) will be part of the program. Follow-up for the identified children is included in Component C.

Overall, allocation of MCH dollars across Components A, B, & C is based upon unmet health care needs identified in the Year 2000 Five Year MCH Needs Assessment. The state assures a fair and equitable method of distributing funds based upon identified needs.

Nevada's MCH unexpended grant balance, as reported in last year's application, was basically expended as planned over the current 2003-2004 biennium. The goal was to leave approximately $150,000 in unexpended grant balance at the end of the upcoming biennium and this goal was met in FY 03. Nevada's Title V Maternal and Child Health Block grant has been fully budgeted through the Legislative process for the 2004-2005 biennium.

Other federal funds administered by the MCH Chief besides the Maternal and Child Health Title V Block Grant Program include a United States Department of Agriculture (USDA) grant for the state WIC program; Abstinence-Only Education, Quentin C. Burdick Program for Interdisciplinary Training and State Systems Development Initiative grants funded by MCHB; Newborn Hearing Screening, Rape Prevention and Education, and Injury Prevention grants from CDC; Sexual Assault Prevention from PHHS, Real Choice Systems Change from CMS and Primary Care and NSHC Search Program from the Bureau of Primary Health Care. The other federal grants provide different services to the populations served by the Maternal and Child Health Block Grant Program in accordance with approved grant proposals.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.